

TRAINING FAMILY THERAPISTS TO WORK WITH FAMILIES WITH
YOUNG CHILDREN: CURRENT PRACTICES IN ACCREDITED FAMILY
COUNSELING/THERAPY PROGRAMS AND RECOMMENDATIONS FOR
THE FUTURE

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This study examined how current family counseling/therapy programs train students to work with families with young children and made recommendations for training in this area based on recommendations of child and family therapy experts and the research and clinical literature. These recommendations explored what knowledge and skills all students should acquire versus students who want to specialize with this population. Changes to accreditation standards were also proposed as well as a description of resources to support changes in program curricula.

Current training was measured by examining curricula from master's level marriage and family counseling/therapy programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) and the Council for Accreditation of Counseling and Related Education Programs (CACREP) and master's level social work programs with a family-related concentration accredited by the Council on Social Work Education Commission on Accreditation (CSWE), the accreditation standards from these three organizations, course syllabi from the COAMFTE and CACREP programs, and surveys of COAMFTE and CACREP program directors (60% response rate). Recommendations for training were obtained through a qualitative

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CHAPTER I

INTRODUCTION

Historically, family therapists have had the tendency to exclude young children from the therapeutic process. Several research studies have demonstrated this propensity (Cederborg, 1997; Greenwood, 1984; Johnson & Thomas, 1999; Korner & Brown, 1990; Rait, 1988; Ruble, 1999). This exclusion occurs despite the notion that there can be no family therapy without children (Ackerman, 1970) and that several reasons have been reported in the literature supporting the inclusion of young children. These reasons consist of the therapist being better able to understand family dynamics (Carr, 1994; Chasin & White, 1989; Dowling & Jones, 1978; Eaker, 1986; Guttman, 1975; Keith, 1986; Malone, 1979; Stoddard, Wilberger, & Olafson, 1993; Zilbach, 1986; Zilbach, Bergel, & Gass, 1972; Zilversmit, 1990) and teach and role model for the adults better ways of interacting and communicating with the children (Brock & Barnard, 1999; Eaker; Guttman; Selekman, 1997; Stoddard et al., 1993; Zilbach et al., 1972), the opportunity to give children a voice in therapy (Cox, 1997; Selekman), the enhancement of the family's potential for change (Keith), parents' expectations that the therapist will include children (Diller, 1991; Kuhel, 1993; O' Brien & Loudon, 1985), and the therapist's ethical responsibility to understand children's therapeutic needs and provide for them (Korner, 1988; Nickerson, 1986).

How one is trained influences whom one focuses on in therapy (Haley, 1973) and what one does with children in therapy (Anderson & Reynolds, 1996). One main reason, then, for the exclusion of young children is family therapists' general lack of training in

working with children (Combrinck-Graham, 1986, 1991; Green, 1994). This insufficient training has been shown through research studies (Doherty & Simmons, 1996; Hines, 1996; Korner & Brown, 1990) and has been reported by several authors (Guerney & Guerney, 1987; Guttman, 1975; Kaslow & Racusin, 1990; Korner, 1988; McDermott & Char, 1974; Nickerson, 1986; Rotter & Bush, 2000; Taffel, 1991; Wachtel, 1994; Zilbach, 1986).

Those who are not trained in working with children have difficulty understanding children and relating to them as individuals (Green, 1994; McDermott & Char, 1974), may ignore their needs (McDermott & Char), may see them primarily as victims of adult projections (Gordetzsky & Zilbach, 1989), and may change to focusing on marital problems too soon in the process of therapy (Rober, 1998). They also are hesitant about including young children in family sessions (Keith, 1986; Korner & Brown, 1990) and when they do include them, they tend to focus little on the children (Guttman, 1975)

Family therapists need sufficient training to work with young children for several reasons. First, young children's problems are a focus of family therapists' practices. In a survey of nearly 900 family therapists in 1987, 22% rated "younger children" among the three most common problems posed to them (Rait, 1988). Among the 14 problems rated, "younger children" was the sixth most rated presenting problem. Hines (1996) completed a follow-up survey of 43 doctoral level and 162 master's level graduates from accredited marriage and family therapy programs who had graduated in the 1980s. The results revealed that 16.56% of master's graduates and 25.64% of doctoral graduates rated "problems with young children" as among the five most common presented problems in

their clinical work. Finally, in a recent survey of 526 family therapists, “child behavior” and “parent-child problems” composed 20.6% of presenting problems to these therapists (Doherty & Simmons, 1996). “Parent-child problems” was the fifth most prevalent presenting problem and “child behavior” was eighth.

In addition, family therapists have an ethical responsibility to acquire and experience adequate training in treating young children. First of all, engaging in treatment that is beyond the bounds of one’s expertise is unethical (American Association for Marriage and Family Therapy, 1998; American Counseling Association, 1995). Secondly, family therapists should know how to appropriately include children in therapy, because children have the right to participate (Carr, 1994) and have their voices be heard (Cox, 1997; Selekman, 1997), they want to be included (Stith, Rosen, McCollum, Coleman, & Herman, 1996), and their parents expect them to be included (Kuehl, 1993; O’Brien & Loudon, 1985). Thirdly, family therapists have an ethical responsibility to understand children’s therapeutic needs and provide for them (Korner, 1988; Nickerson, 1986) in order to promote the welfare of children as described in ethical codes (American Association for Marriage and Family Therapy, 1998; American Counseling Association, 1995).

Furthermore, adequate training to work with young children in family therapy would address criticisms of the family therapy field. These criticisms include family therapists not sufficiently addressing the needs and concerns of children (Dare & Lindsey, 1979; Kalsow & Racusin, 1990) and their intrapsychic or personality problems (Dare &

Lindsey; Guerney & Guerney, 1987; Wachtel, 1990, 1991) and not engaging them in the therapeutic process in a developmentally appropriate way.

There is a scarcity of literature that addresses how family therapy programs train students to work with young children (Korner, 1988). Studies are needed then, to determine the most effective way to train therapists to have knowledge in both individual and family dynamics (Cordell & Allen, 1997) and making therapy developmentally appropriate for all family members including children.

Statement of the Problem

The problem addressed in this study was a) the lack of sufficient training in family counseling and therapy programs in working with families with young children (Guerney & Guerney, 1987; Guttman, 1975; Kaslow & Racusin, 1990; Korner, 1988; McDermott & Char, 1974; Nickerson, 1986; Rotter & Bush, 2000; Taffel, 1991; Watchel, 1994; Zilbach, 1986) and b) the dearth of studies focusing on how programs train students in this area. This lack of training results in family therapists either excluding children from therapy or not adequately addressing their needs and concerns in a developmentally appropriate way (Dare & Lindsey, 1979; Kaslow & Racusin, 1990).

Purpose of the Study

The purpose of this study was a) to examine how current family counseling and therapy programs train students to work with young children and families with young children and b) to make recommendations for training family counselors and therapists to work with young children and families with young children. These recommendations were developed by comparing how training programs currently train students with what

the experts in the child and family counseling and therapy fields and in the research and clinical literature recommend. These recommendations also explored a) what knowledge and skills all students should acquire in order to work with young children in family therapy and b) what knowledge and skills students who want to specialize with this population should obtain.

Synthesis of Related Literature

The review of the literature focuses on three primary areas: (a) exclusion of children from family therapy, (b) criticisms of family therapy with children, and (c) family therapists' need for more sufficient training in working with children and families with young children.

Exclusion of Children from Family Therapy

In the past, family therapists have tended to exclude young children from the therapeutic process. Several research studies have demonstrated this propensity.

Research studies. Korner and Brown (1990) surveyed 173 family therapists in 1985 and 1986 about their beliefs and practices concerning the exclusion of children from therapy. Nearly one quarter of the respondents reported having no coursework or supervision in working with children and almost half thought their training was inadequate. Less than one third reported that more than 25% of their practice involved children. Finally, a little over a third expressed a preference for working with families with children. The exclusion of children was directly related to the amount of training the therapists had had as well as their comfort level in working with children. The authors

asserted that these results pointed to the need for training that would increase competence and comfort level in working with children.

In another survey of nearly 900 family therapists in 1987, only 3% reported seeing children individually (Rait, 1988). Most of the time (36%) the therapists saw whole families. Also, Greenwood (1984) surveyed 126 family therapists and found that most of the therapists were in favor of including children, but 70% of them did so less than half the time. One possible reason given for the exclusion was lack of academic and experiential training in child development.

In still another study, Cederborg (1997) conducted a time space analysis of family therapy sessions involving a child aged four to seven. The results revealed that 61% of the time, the children were stand-by participants meaning they were present but not participating and may or may not have been listening. Twenty-five percent of the time they were playing by themselves or with siblings or were out of the range of hearing the therapy talk. The remaining 14% of the time they were interacting verbally and nonverbally with the adults. Only 3.5% of the total words spoken in the sessions were by the children. Cederborg interpreted these findings as children having the status of “nonpersons” (p. 37) in family therapy.

Yet, in another study, the results from a survey of 143 family therapists (Johnson & Thomas, 1999) showed that significantly more therapists agreed than disagreed with the view that it is permissible for therapists to exclude children from therapy sessions if the therapists preferred not to work with children or were not comfortable with them. The

authors raised the question of whether this discomfort in including children was due to lack of training, theoretical orientation, simple preference, or other factors.

Finally, the results from a systematic research synthesis of the non-empirical and empirical literature in the area of children in family therapy (Ruble, 1999) revealed that family therapists do not regularly include children in family therapy. The main reason cited for this exclusion was lack of training in working with children.

Reasons for exclusion. There are several possible reasons for the exclusion of young children from family therapy. The first reason concerns the nature of children themselves. For example, young children are unable to express themselves verbally and have difficulty understanding abstract ideas (Bloch, 1976; Carr, 1994; Gil, 1994; Korner, 1988; McDermott & Char, 1974; Zilbach, 1982, 1986; Zilbach et al., 1972). They often participate on a nonverbal level and do not respond to direct questions (Dare & Lindsey, 1979; Dowling & Jones, 1978; Guttman, 1975; Zilbach, 1986). In addition, the in-session behavior of young children may be puzzling or annoying to family therapists (McDermott & Char) or make them feel uncomfortable (Gordetsky & Zilbach, 1989). Children are often restless and unable to sit through long family sessions (Bloch; Carr; Korner; McDermott & Char; Zilbach, 1982, 1986; Zilbach et al.). They may be messy, noisy, disruptive, and distracting (Combrinck-Graham, 1991; Dowling & Jones; O'Brien & Loudon, 1985). They may also become bored (O'Brien & Loudon; Villeneuve, 1979) and may be silent and withdrawn (O'Brien & Loudon).

Another reason for exclusion focuses on family therapists themselves. First, therapists may want to protect children because they may witness unpleasant family arguments,

learn family secrets (Chasin & White, 1989; Zilbach, 1986; Zilbach et al., 1972), and be overwhelmed by complex situations during family sessions (Villeneuve, 1979). Second, therapists may not want their own feelings and memories from childhood (Dowling & Jones, 1978; Gordetsky & Zilbach, 1989; O'Brien & Loudon, 1985; Zilbach, 1982, 1986; Zilversmit, 1990) or their own issues as parents to be aroused that may result in overidentification with either the parent or the child (Bloch, 1976). Third, children's behavior may lead to feelings of anxiety, frustration (Guttman, 1975; Zilbach, 1986), rejection, embarrassment, humiliation, and lack of confidence and credibility on the part of the therapist (O'Brien & Loudon). Fourth, therapists may also feel incompetent, because dealing with the complexity of both adult and child material simultaneously is difficult (Dowling & Jones). Fifth, therapists may be uncomfortable with or just may not like children (Combrinck-Graham, 1991). Sixth, therapists may be reluctant to play with children based on their own attitudes, knowledge, and experience of play (Zilbach, 1982, 1986). Similarly, family therapists may exclude children because they are often not trained to work with them (Combrinck-Graham, 1986, 1991; Green, 1994). Finally, therapists may be concerned that their expertise with children will alienate the parents (Chasin & White, 1989) or make them feel in competition with them.

Still another reason for exclusion involves the objections of parents and children. For instance, parents may not want their child to miss school by coming to therapy. They may also have concerns that their child be viewed as "normal" (Korner, 1988; Zilbach, 1986; Zilbach et al., 1972). In addition, parents may want privacy in the therapy session regarding certain issues such as their sex life (Dowling & Jones, 1978). Children

themselves may object to therapy in such a way that they express the doubts and fears of the rest of the family about engaging in therapy (Korner; Zilbach, 1986; Zilbach et al.).

Furthermore, children may be excluded from family sessions for theoretical reasons. The therapist may believe that the presenting problem is actually a marital or parental problem expressed through the children (Chasin & White, 1989; Dare & Lindsey, 1979; McDermott & Char, 1974; Wachtel, 1990, 1991, 1994). Individual sessions with the child may also reinforce the family's idea that the problem resides within the child, and the child then continues to be scapegoated (Kuehl, 1993). However, only Bowenian theory specifically calls for the exclusion of children from family therapy (Chasin & White; Diller, 1991). Because Bowen believed that parental problems are projected onto the children, his approach in therapy was to take the focus off the children as quickly as possible and remove them from the sessions in order to concentrate on the relationship between the parents (Bowen, 1978).

Finally, the founders of the family therapy field did not focus on children but instead concentrated on adult schizophrenia and adolescent delinquency (Green, 1994). In addition, few of these leaders had specific training in child therapy (Guerney & Guerney, 1987). Even though some early family therapists were child psychiatrists, the work of the leaders in family therapy neglected the role of children in family therapy (Malone, 1974).

Excluding children is ironic, for "without engaging the children in a meaningful interchange across the generations, there can be no family therapy" (Ackerman, 1970, p. 403). Similarly Keith (1986) stated, "a family is not a family when the children are excluded" (p. 10). In addition, by ignoring children, family therapists fail to adopt a truly

holistic, contextual, and systemic approach that is the hallmark of the family therapy field (Bloch, 1976; O'Brien & Loudon, 1985). Furthermore, when children are not included, family interactions are distorted (Combrinck-Graham, 1991), and the family's current situation is difficult to understand (Zilbach et al., 1972).

Benefits of inclusion. Several benefits can occur when children are included in family therapy. First, the therapist is better able to understand family dynamics. This understanding comes from the ability to observe whole family interactions during the therapy session (Carr, 1994; Chasin & White, 1989; Dowling & Jones, 1978; Eaker, 1986; Guttman, 1975; Keith, 1986; Malone, 1979; Stoddard, et al., 1993; Zilbach, 1986; Zilbach et al., 1972; Zilversmit, 1990). This observation allows the therapist to better comprehend the structure of the family, the roles the family members play, and how the interactions of family members maintain the presenting problem (Minuchin, 1974). The information children provide also helps the therapist understand the family. Children can offer this information, because they are less defensive and guarded than adults and can be more spontaneous, direct, and honest (Anderson, 1993; Brock & Barnard, 1999; Carr; Chasin & White; Korner, 1988; Zilbach, 1986; Zilbach et al.). Through both verbalization and play, children "provide valuable clues to the underlying feelings and issues in the family" (Zilbach, 1982, p. 67). They furnish access to the family's unconscious (Keith) as they may express issues that have been repressed or avoided by the adults (Dowling & Jones). Also, they communicate the family's feelings and needs (Anderson; Keith; Zilbach, 1986). Because therapists are better able to understand the family through observation of their interactions and the information the children provide, children may

be considered as allies of the therapist or even cotherapists (Selekman, 1997; Taffel, 1991; Zilbach, 1986; Zilversmit).

Another benefit of including children is the opportunity to give them a voice in therapy (Cox, 1997; Selekman, 1997). Children are able to communicate their own feelings and needs (Guttman, 1975; Keith, 1986; Taffel, 1991) which helps the therapist to discover their view of the situation (Carr, 1994) and to understand them as individuals (Dare & Lindsey, 1979).

Involving children in family sessions also allows the therapist to be able to teach and role model for the adults better ways of interacting and communicating with the children (Brock & Barnard, 1999; Eaker, 1986; Guttman, 1975; Selekman, 1997; Stoddard et al., 1993; Zilbach et al., 1972). The therapist can then assist in the development of healthy relationships in the family (Carr, 1994). These new ways of interacting can prevent problems in the future (Brock & Barnard).

Furthermore, families change more slowly when children are excluded (Keith & Whitaker, 1981) so, including them enhances the family's potential for change (Keith, 1986). Children are often motivated for change (Korner, 1988; Taffel, 1991) and have the ability to alter the family system (Wachtel, 1990). For instance, they can have an effect on the family by playing the role of peacemaker (Zilbach et al., 1972) or facilitating the expression of emotion in the family (Dowling & Jones, 1978).

Additionally, family therapists have an ethical responsibility to understand children's therapeutic needs and provide for them (Korner, 1988; Nickerson, 1986). This responsibility is in line with Section One of the AAMFT Code of Ethics that states,

"Marriage and family therapists advance the welfare of families and individuals"

(American Association for Marriage and Family Therapy, 1998). It also fits with Section A of the ACA Code of Ethics that asserts, "The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients" (American Counseling Association, 1995). Children have the right to participate in a therapeutic process that is geared toward helping them and their families (Carr, 1994). They have the right to have their voices be heard (Cox, 1997; Selekman, 1997). Children also want to be included in family therapy sessions by being physically in the room and through play and activities (Stith et al., 1996), and including them shows they are valued as people (Brock & Barnard, 1999).

Lastly, parents tend to expect that the therapist will have individual sessions with the child or will focus on the child. When these sessions do not occur, the parents may become resistant or disappointed with family therapy (Kuehl, 1993; O'Brien & Loudon, 1985). Quoting Chasin, "people expect family therapists to be good at working with children, but often they have no training or information to do this work, as well as no experience, no interest, and no energy" (Diller, 1991, p. 23). Including the children, then, addresses the parents' wishes and shows respect for the parents.

Criticisms of Family Therapy With Children

When family therapists do include children in the therapeutic process, they have been criticized for not adequately addressing the needs and developmental concerns of the individual child (Dare & Lindsey, 1979; Kaslow & Racusin, 1990) as well as the child's intrapsychic problems (Guerney & Guerney, 1987). Another criticism of family therapy

is that changes in the personality structure of the child may not occur (Dare & Lindsey). Along these lines, resolving family issues alone may not relieve the child's problems. In addition, children in family therapy may not be given specific, needed help to resolve difficulties such as impulse control, peer problems, low frustration tolerance, and low self-esteem (Wachtel, 1990, 1991), and their inner resources may not be sufficiently developed.

One reason given for these inadequacies is the criticism that the traditional systemic thinking of the family therapy field views the child not as a unique person but instead as a "symptomatic cog in a very creaky machine" (Diller, 1991, p. 23) or as a person playing a family role (Wachtel, 1992, 1994). Similarly, "knowing the whole does not mean that we understand all of the parts, particularly a developing and unfolding one" (McDermott & Char, 1974, p. 430), i.e., understanding the family as a system may involve not understanding the children as individuals.

Another reason for family therapy's deficiency in focusing on the child's needs is that traditionally the primary therapy tends to be with the parents and is mainly a verbal process (Levant & Haffey, 1981). The therapist tends to talk to the parents while the children sit passively in chairs and are only able to give short responses to the therapist's questions (O'Brien & Loudon, 1985). Children are often placed to the side to be observed by the adults and are encouraged to participate only in ways that give value to the rest of the members in the therapy room. Therefore, children are not given equal status with the adults (Guerney & Guerney, 1987). Frequently, family therapy becomes marital therapy in the presence of the child (Dare & Lindsey, 1979) even though the child's problems

may not be a result of marital conflict (Chasin & White, 1989; Dare & Lindsey, 1979; McDermott & Char, 1974; Wachtel, 1990, 1991, 1994).

The family therapist may provide toys and play material for the child, but these are usually utilized as a diversion or a relief of any anxiety the child may experience during the session. When children are included, the therapist often does not communicate with the child through play, but instead interprets the child's play to the parents or may use the play to assess the family (Guttman, 1975; Levant & Haffey, 1981; Zilbach et al., 1972).

Need for More Sufficient Training

The issues for which family therapy has been criticized may be due to the therapists' training; for, how therapists are trained influences whom they focus upon in therapy (Haley, 1973) and specifically, what they do with children in family therapy (Anderson & Reynolds, 1996). Those who are not trained in working with children will have difficulty understanding them and relating to them as individuals (Green, 1994; McDermott & Char, 1974), may ignore their needs (McDermott & Char), may see them primarily as victims of adult projections (Gordetzsky & Zilbach, 1989), and may change to focusing on marital problems too soon in the process of therapy (Rober, 1998). "Without a sound knowledge of the psychological needs of children, the work of the family therapist will be incomplete, inadequate, and probably distorted" (Malone, 1974, p. 438).

Children are often excluded from family sessions, because family therapists are not trained to work with them (Combrinck-Graham, 1986, 1991; Green, 1994). Family therapists who have little or no training in child therapy do not pay much attention to children in practice (Guttman, 1975) and are hesitant about including them in family

sessions (Keith, 1986; Korner & Brown, 1990). The results from Korner and Brown's (1990) study indicated that the family therapists' tendency to exclude children was directly related to their amount of coursework and supervision and perceived adequacy of training.

Two other research studies have demonstrated family therapists' lack of training in working with children. The results of a survey of 526 family therapists revealed that only 62.4% felt competent in treating children as a population and 47% felt competent in doing child therapy as a mode of treatment (Doherty & Simmons, 1996). The findings from a follow-up survey of 43 doctoral level and 162 master's level graduates from accredited marriage and family therapy programs in the 1980s showed that the graduates felt only minimally prepared for doing individual therapy with children and moderately prepared for dealing with problems with young children (Hines, 1996). The graduates also recommended an increase in training in individual therapy with children and in dealing with problems with young children.

Few current family therapists have had training in child therapy (Guerney & Guerney, 1987). How to work with young children and include them in family therapy tends to be neglected in the training of family therapists (Guttman, 1975; Korner, 1988; Rotter & Bush, 2000; Wachtel, 1994). Many family therapists feel unprepared and lack confidence as to how to effectively include children in family sessions (O' Brien & Loudon, 1985; Rotter & Bush). Family therapy training does not adequately attend to the developmental needs of young children (Kaslow & Racusin, 1990) as family therapists tend not to receive training in child development (McDermott & Char, 1974).

More specifically, “many family therapists have not received basic training in clinical work with young children (i.e., child development, child psychopathology, child assessment, or child therapy)” (Green, 1994, p. v). Many family therapists also do not have the skills necessary to communicate effectively with children (Taffel, 1991). In addition, “few family training programs actually teach or even discuss playing with children in family therapy” (Zilbach, 1986, p. 14). Little attention in family therapy programs has been given to how play can be incorporated into family sessions (Stith et al., 1996). “The field of family therapy per se has been relatively remiss in developing more innovative ways for and training in incorporating the child into family work” (Nickerson, 1986, p. 63).

“Knowledge of child development and training in child and play therapy are essential to the therapist working with families” (Gordetsky & Zilbach, 1989, p. 97). This knowledge is important because for children, the verbal mode of communication used by adults is inadequate in eliciting their participation in therapy (Villeneuve, 1979; Villeneuve & La Roche, 1993). In fact, inexperienced family therapists tend to only interact with children in verbal ways (Villeneuve). Children tend to utilize more nonverbal, concrete modes of expression such as play, games, and action (Guttman, 1975; O’Brien & Loudon, 1985; Schatz, 1998; Stoddard et al., 1993; Villeneuve; Zilbach, 1982; Zilversmit, 1990). Through play, children are more relaxed and forthcoming in expressing their conflicts and feelings such as anxiety and fear (Dowling & Jones, 1978; Orgun, 1973; Wachtel, 1990; Zilbach et al., 1972) and revealing and expressing the self (Anderson, 1993; Hardaway, 1990; Wolfe & Collins-Wolfe, 1983). Play can be used to

understand the child's intrapsychic and interpersonal world that includes the family (Brock & Barnard, 1999; Dowling & Jones; Villeneuve & La Roche).

Therefore, a truly systemic orientation, the hallmark of the family therapy field, should take into account the child's individual biopsychosocial factors as well as the influence of the child's ecosystem including family, school, peers, neighborhood, social services, and ethnicity and class (Diller, 1991). The child's biopsychosocial factors include a focus on the child's development. The child's individual factors and ecosystem reciprocally influence each other.

From child therapy, then, family therapists can learn how to fully attend to, include, and intervene with the child by communicating through the child's language of play (Guerney & Guerney, 1987). Developmental concepts such as separation/individuation and attachment help the therapist better understand the child's needs (Malone, 1979). Not only is it important that the therapist be able to utilize the child's behavior in individual and family sessions for assessment purposes, but also that the child benefits therapeutically from the session (Dowling & Jones, 1978). Child therapy has an abundance of techniques for helping children therapeutically.

As a result, to include children in family therapy effectively, one must be both a child and a family expert (McDermott & Char, 1974). Consequently, family therapists can benefit from having training in child therapy (Kuehl, 1993). The results of the Komer and Brown (1990) study also pointed to the need for training in working with children to increase competence and help therapists feel comfortable in working with them. This

training can help therapists better understand and attend to the developmental needs of children (Kaslow & Racusin, 1990).

Summary

Family therapists have had the tendency to exclude young children from the therapeutic process. When they do include children in family therapy, however, they have been criticized for not engaging them in a developmentally appropriate way or in a way that adequately addresses their needs and concerns (Dare & Lindsey, 1979; Kaslow & Racusin, 1990).

One main reason for this exclusion of young children and criticism concerning family therapists' work is their general lack of training in working with children (Combrinck-Graham, 1986, 1991; Green, 1994). This exclusion occurs despite three notions. First, young children's problems are often a presenting concern in family therapists' practices. Second, there is a host of reasons provided in the literature describing benefits to the inclusion of children in family therapy. Third, not including children or including them without having had appropriate training is unethical.

As a result, family counselors and therapists should have adequate education and training in the inclusion of young children. There is a dearth of literature addressing how family counseling and family therapy programs train counselors and therapists to work with children and families with young children. The current study will fill this gap in the literature and will make recommendations for educating family counselors and therapists to work with young children and families with young children.

This study will also investigate options for education and training by exploring what all students in family counseling and therapy should know and experience regarding young children in family counseling and therapy and what those students who want to specialize with this population should know and experience.

CHAPTER II

METHODS AND PROCEDURES

This chapter reports the research questions guiding this study; definition of terms used in the study; a description of the research design including participants, collection of data, analysis of data, and recommendations for training; and the reliability and validity of the study.

Research Questions

This study proposed to answer the following research questions.

1. What is the current description and structure of training in family counseling/therapy with young children in master's level marriage and family counseling/therapy programs accredited by the Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE) or the Council for Accreditation of Counseling and Related Education Programs (CACREP) and in master's level social work programs accredited by the Council on Social Work Education Commission on Accreditation (CSWE) who have a family-related concentration?
2. How does the research and clinical literature suggest family counselors and therapists should be trained in order to work with young children and families with young children?

3. How do experts in the child and family counseling/therapy field recommend family counselors and therapists should be trained in order to work with young children and families with young children?
4. How does the current description and structure of education in family counseling/therapy with young children in marriage and family counseling/therapy training programs accredited by COAMFTE and CACREP compare to the recommendations proposed by the research and clinical literature and child and family counseling/therapy experts?

Definition of Terms

Family counseling/therapy involves conjoint family sessions in which the therapist utilizes a family systems perspective. A family can be blood relatives or anyone living together in a household. In family counseling/therapy, the unit of treatment is the set of relationships in which the person is imbedded (American Association for Marriage and Family Therapy, 1999b).

Young children are children aged two to ten. This age range was chosen for this study, because these are the ages at which a child, while able to speak, has difficulty in family counseling/therapy sessions where the primary mode of communication is verbal and on an adult level (Orgun, 1973).

A description and structure of training in family counseling/therapy with young children includes a detailed description of the child-related courses, practicum, and internship in a marriage and family counseling/therapy program as well as clinical

facilities supporting the program and the teaching and clinical experience level of faculty in the program.

A marriage and family counseling/therapy program is a master's level program in marriage and family counseling or marriage and family therapy accredited by COAMFTE or CACREP. Master's level programs were chosen for this study, because this is the degree necessary to become licensed to practice as a therapist or counselor. Psychology programs were not included, because they only have an accredited family psychology tract at the doctoral level.

The Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE) is a specialized accrediting body established by the American Association for Marriage and Family Therapy (AAMFT) that accredits master's, doctorate, and postgraduate degree clinical training programs in marriage and family therapy throughout the United States and Canada (American Association for Marriage and Family Therapy, 1999a).

The Council for Accreditation of Counseling and Related Education Programs (CACREP) is a specialized accrediting body affiliated with the American Counseling Association (ACA) that accredits master's degree programs in community counseling, marriage and family counseling/therapy, mental health counseling, school counseling, student affairs practice in higher education with professional practice and college counseling emphases, and specializations in career counseling and gerontological counseling as well as doctoral degree programs in counselor education and supervision (American Counseling Association, 1999a; 1999c).

The Council on Social Work Education (CSWE) is a national association that sets and maintains social work policy and program standards, accredits bachelor's and master's level programs, promotes research and faculty development, and advocates for social work education (Council on Social Work Education, 2000b).

An expert in child and family counseling/therapy is someone with at least nine years of clinical experience doing child and/or family counseling/therapy and has published at least two articles or books in the research or clinical literature.

Recommendations for training family counselors and therapists to work with young children and families with young children consists of a general description of recommendations regarding the child-related course material and experiential activities that should be included in a master's level marriage and family counseling/therapy program as well as a proposal for the clinical facilities supporting the program and the teaching and clinical experience level of faculty in the program.

Research Design

This study involves a mainly qualitative research design due to the descriptive nature of the research questions. Qualitative methods allow the study of a phenomenon in depth and detail without being constrained by preconceived categories of analysis (Patton, 1990).

Participants

The original intent of this study was to examine accredited family counseling or therapy programs in all mental health fields. However, psychology does not have accredited master's level programs so they were not included in this study. In addition,

social work programs with a family-related concentration were not included as survey participants after investigating their program curricula and accreditations standards. This decision was made, because these programs tended to have a more general family services focus rather than an emphasis in family therapy per se. Therefore, the participants of this study included respondents to a survey sent to all master's level programs in marriage and family counseling/therapy throughout the United States that are accredited by either COAMFTE or CACREP, in particular the directors of these programs. Other participants included respondents to an interview sent to experts in child and family counseling/therapy.

Collection of Data

Qualitative research involves three methods of data collection including in-depth, open-ended interviews, direct observation, and written documents. Written documents may consist of open-ended written responses to survey questionnaires (Patton, 1990). Six ways of collecting data were utilized in this study including collection of program curricula, a survey questionnaire of accredited programs, collection of course syllabi, collection of accreditation standards, portions of research and clinical literature referring to training in family counseling/therapy with young children, and interviews of experts in child and family counseling/therapy. The purpose of the first four types of data was to gain information about the description and structure of current training in family counseling/therapy with young children and thereby, answer research question one. The purpose of the last two types of data was to obtain recommendations for training family counselors and therapists to work with young children and families with young children.

These data answered research questions two and three. Research question four was answered by comparing the first four types of data to the last two.

Program Curricula

A list of all the master's level marriage and family counseling/therapy programs in the United States accredited by either COAMFTE as of March 20, 2000 or CACREP as of 1999 was obtained by consulting a directory of programs available on-line (American Association for Marriage and Family Therapy, 2000b; American Counseling Association, 1999b). A list of all the master's level social work programs with a family-related concentration accredited by CSWE Commission on Accreditation as of February 23, 2000 was obtained by consulting a directory of programs available on-line (Council on Social Work Education, 2000a) and a summary of information about social work programs (Council on Social Work Education, 1999). Curricula for the accredited marriage and family counseling/therapy programs and accredited social work programs with a family-related concentration were found by consulting the websites for these programs on the internet as well as on-line university graduate catalogs and bulletins whenever possible. When curricula and course descriptions were not available on-line, the university or program was sent an email or letter to request a copy of curricula and course descriptions. This information was usually received through brochures and graduate catalogs and bulletins.

A list was made of the child-related courses available in each program. Usually the words "child," "children," "parent," "parents" or "development" had to be in the title in order to be included in the list, however cognitive development and early childhood

education courses were not counted but all other child development courses were included. In addition, more general classes such as research, ethics, and practicum, internship, and field placement courses were not included in the list unless their entire focus was on children. Finally, the course description of each of the child-related courses was obtained from the websites.

Survey Questionnaire

The survey in the present study was designed using the following steps described by Fowler (1993) and Rea and Parker (1992). First, a focus group of counselor education doctoral students and faculty was consulted to determine possible topic areas and information to include in the survey. Second, a draft of possible survey questions was submitted to the focus group for consideration. Several texts were consulted in order to design the format and questions of the survey including Berdie, Anderson, and Niebuhr (1986), Fowler (1993), Gall, Borg, and Gall (1996) and Rea and Parker (1992). Third, the draft was revised using the comments of the focus group. Fourth, the revised draft of the survey was pretested as recommended by Gall et al. (1996) by mailing it to three marriage and family counseling/therapy program directors. The mailing consisted of a cover letter; the revised survey; a self-addressed, stamped, return envelope; and a package of gum as an incentive to complete the survey and as appreciation for participating in the study. The first page of the survey was an informed consent form describing the confidentiality guidelines of the study. The last page of the survey expressed appreciation for the respondent's participation and included a form for the respondent to fill out in order to receive a summary of the study's results.

The cover letter was designed according to the guidelines of Berdie et al. (1986), Fowler (1993), Gall et al. (1996), and Rea and Parker (1992). (See Appendix A.) The cover letter included the name of the organization involved in the study (University of North Texas); the name, address, phone number, and email address of the primary investigator (Jodi Crane); the purpose of the study (see Chapter I); characteristics of the respondent that led to inclusion in the study (director of accredited marriage and family counseling/therapy program); a description of the methods for maintaining confidentiality of responses (see paragraph below); an offer to send a copy of the study's results; and return mail instructions. Statements were also made explaining the importance of participation and the benefits for doing so and requesting the respondents to assess the survey for clarity, comprehensiveness, and acceptability.

Confidentiality was maintained by assigning a code number to each survey to track the receiving of responses. A list of code numbers and names of programs were only available to the primary investigator. The surveys also did not ask for any identifying information such as the name of the university, institution, or program director. In addition, all survey responses and course syllabi are confidential and were only seen by the primary investigator. Finally, using the results of the pretest, a final draft of the survey was completed.

All of the program directors were first precontacted via a letter identifying the primary investigator, discussing the purpose of the study, and requesting the program's cooperation. (See Appendix B.) According to Gall et al. (1996), precontacts tend to increase the response rate. The final draft of the survey (see Appendix C) was mailed to

these same program directors one week later along with a cover letter; a self-addressed, stamped, return envelope; and a package of gum as an incentive to complete the survey and as appreciation for participating in the study. The cover letter included the same items as the cover letter used in the pretest of the survey with the exception of not asking the respondent to assess the survey. (See Appendix D.)

It is important to follow-up with nonrespondents in order to increase the response rate (Gall et al., 1996). The outline for the follow-ups conformed with recommendations made by Fowler (1993) and Rea and Parker (1992). Two weeks after the initial mailing of the surveys a follow-up postcard was mailed to all nonrespondents reminding them to fill out and return the survey and thanking them for their cooperation. (See Appendix E.) Four weeks after the initial mailing the primary investigator sent an email to any program directors who had not responded reminding them to do so and offering any help in filling out the survey. Finally, six weeks from the initial mailing a new cover letter (see Appendix F) and another copy of the survey was sent to all nonrespondents.

Course Syllabi

As part of the survey, the directors were asked to submit copies of syllabi of child-related courses, both required and electives, offered to students in their programs as listed on page two of the survey. They were told either to send the syllabi with the survey or under separate cover.

Accreditation Standards

The most recent copies of the accreditation standards of COAMFTE, CACREP, and CSWE Commission on Accreditation were obtained (Commission on Accreditation of

Marriage and Family Therapy Education, 1997; Council for Accreditation of Counseling and Related Education Programs, 1994; Council on Social Work Education Commission on Accreditation, 1994a, 1994b). All three accreditation standards were available on-line (American Association for Marriage and Family Therapy, 2000a; American Counseling Association, 2000; Council on Social Work Education, 2000a).

Research and Clinical Literature

Besides field observations and interviewing, sources of data for qualitative analyses may also include “published documents of all kinds and private documents like letters and diaries” (Strauss, 1987, p. 26) or as referred to by Lincoln and Guba (1985) as records and documents. A record has the “purpose of attesting to an event or providing an accounting” (p. 277). A document is “any written or recorded material other than a record that was not prepared specifically in response to a request from the inquirer” (p. 277). The data in this study fall into the latter category of private documents.

Quotations referring to how family counselors and therapists should be trained to work with young children and families with young children were collected by referring to articles such as in the following journals in the past 30 years: American Journal of Family Therapy, Australian and New Zealand Journal of Family Therapy, Contemporary Family Therapy: An International Journal, The Family Journal: Counseling and Therapy for Couples and Families, Family Process, Family Therapy, Family Therapy Networker, Journal of Family Psychology, Journal of Family Psychotherapy, Journal of Family Therapy, Journal of Marital and Family Therapy, and Journal of Systemic Therapies. In addition, appropriate articles and books were found through a search of the PsychLit

database using the key words “family counseling,” “family therapy,” “children,” “education,” and “training.” Still other articles and books were collected by consulting the reference lists of previously obtained articles and books.

Each quotation was copied verbatim and examined again to insure accuracy of duplication. To insure that the name of the article or book referenced did not influence the data analysis, each article or book was assigned a reference code. The first two numbers of the code refer to the reference number of the article or book. The second two numbers of the code refer to the publication year. The final two numbers refer to the quotation number. (See Appendix G for a list of references and reference numbers and Appendix H for a list of the quotations and their code numbers.)

Expert Interviews

Interviewing can assume many forms including individual, face-to-face interviews; face-to-face group interviews; mailed or self-administered questionnaires; and telephone surveys. Interviews can also be structured, semistructured, or unstructured (Fontana & Frey, 1994). In a key informant interview, “the interviewer collects data from individuals who have special knowledge or perceptions that would not otherwise be available to the researcher” (Gall et al., 1996, p. 306). This study utilized key informant interviews in the form of structured, mailed questionnaires.

The expert interview was designed using steps similar to the design of the survey. First, a focus group of counselor education doctoral students and faculty was consulted to determine possible topic areas and information to include in the interview. Second, a draft of possible interview questions was submitted to the focus group for consideration.

Several texts were consulted in order to design the format and questions of the interview including Berdie et al. (1986), Fowler (1993), Gall et al. (1996), and Rea and Parker (1992). Third, the draft was revised using the comments of the focus group. Fourth, the revised draft of the interview was pretested by mailing it to three experts in child and family counseling/therapy. The mailing consisted of a cover letter; the revised interview; a self-addressed, stamped, return envelope; and a package of gum as an incentive to complete the interview and as appreciation for participating in the study. The last page of the interview again expressed appreciation for the expert's participation and included a form for the respondent to fill out in order to receive a summary of the study's results.

The cover letter was designed according to the guidelines of Berdie et al. (1986), Fowler (1993), Gall et al. (1996), and Rea and Parker (1992). (See Appendix I.) The cover letter included the name of the organization involved in the study (University of North Texas); the name, address, phone number, and email address of the primary investigator (Jodi Crane); the purpose of the study (see Chapter I); characteristics of the respondent that led to inclusion in the study (expert in child and family counseling/therapy); a description of the methods for maintaining confidentiality of responses (see paragraph below); and an offer to send a copy of the study's results. Statements were also made explaining the importance of participation and the benefits from doing so as well as requesting the experts assess the interview for clarity, comprehensiveness, and acceptability.

Confidentiality was maintained by assigning a code number to each interview to track the receiving of responses. A list of code numbers and names of the experts were only

available to the primary investigator. The interviews also did not ask for any identifying information such as the name of the expert. In addition, all interview responses are confidential and were only seen by the primary investigator and the research team. Finally, using the results of the pretest, a final draft of the interview was completed.

A list of experts in child and family counseling/therapy was obtained through a method similar to snowball or chain sampling (Lincoln & Guba, 1985; Patton, 1990). In this type of sampling, a few members are first identified to be part of the sample. The members, in turn, are asked to identify other possible members. For this study, an initial list of twenty experts was acquired by searching the research and clinical literature for authors who publish extensively in the area of child counseling/therapy or family counseling/therapy with young children and by consulting with the research team. As part of the interview, members of this initial list were asked to provide names of additional people to be interviewed. Three appropriate names were provided by the respondents.

All of these experts were first precontacted via a letter identifying the primary investigator, discussing the purpose of the study, and requesting the expert's cooperation. (See Appendix J.) The final draft of the interview (see Appendix K) was mailed to these experts one week later along with a cover letter; a self-addressed, stamped, return envelope; and a package of gum as an incentive to complete the interview and as appreciation for participating in the study. The cover letter included the same items as the cover letter used in the pretest of the interview with the exception of not asking the expert to assess the interview. (See Appendix L.)

Two weeks after the initial mailing of the interview a follow-up postcard was mailed to all nonrespondents reminding them to fill out and return the interview and thanking them for their cooperation. (See Appendix E.) Four weeks after the initial mailing the primary investigator sent an email to any experts who had not responded and whose email addresses were available reminding them to do so and offering any help in filling out the interview. Six weeks from the initial mailing a new cover letter (see Appendix M) and another copy of the interview was sent to all nonrespondents.

Analysis of Data

All types of data were analyzed in either of two ways, descriptive data analysis or the constant comparative method (Glaser & Strauss, 1967).

Descriptive Data Analysis

Descriptive data analysis was used on responses to the closed-ended questions of the survey questionnaires and the expert interviews. This analysis was also applied to the program curricula, course syllabi, and accreditation standards by first developing a coding system. Descriptive data analysis involved computing frequency distributions and calculating measures of central tendency including means, medians, and modes. This analysis was used to answer research question one.

Program curricula. Required child-related courses were analyzed separately from elective child-related courses. Elective courses included both listed elective courses and any other child-related courses in the program or department. Both the required and elective courses were counted in one of the following categories based on their course descriptions: Lifespan Development, Family Development, Other Development, Parent-

Child Relationships, Child Psychopathology, Child Assessment, Child Abuse, Antisocial Behavior, Child-Related Laws, Child Policy & Services, Child Placement, Cultural Influences on Children, Special Populations, Parent Education, Child Psychotherapy, Play Therapy, Family Play Therapy, Child Group Therapy, Parent-Child Therapy, Family Therapy with Children, School Therapy, Practice, and Other.

The Family Development category included courses about the stages of the family lifecycle. The Other Development category comprised courses on development that did not fit in either the Lifespan or Family Development categories. The Parent-Child Relationships category contained courses with titles such as Parent-Child Interaction that were focused more on theory than on intervention. The Child Assessment Category consisted of courses related to the testing and appraisal of children. The Child Policy & Services category included courses on child welfare and administration in addition to child policy and services. The Special Populations category comprised courses about such topics as children with disabilities, mental retardation, and chronically ill children. The Child Psychotherapy category contained courses on theory and methods of intervention with children that may or may not include play therapy. The Parent-Child Therapy category consisted of courses about theory and methods of intervention with the identified child client and the child's parents. The Family Therapy with Children category included theory and methods of intervention with the whole family including the siblings of the identified child client and may or may not include family play therapy. The School Therapy category comprised introductory school counseling courses and

courses involving working with children in the school setting and with other school personnel.

The CSWE courses tended to use the word “practice” in their titles. When these practice courses were mainly about intervention they were counted in the appropriate intervention category, otherwise they were put in the Practice Category. Also in the CSWE programs, if a Human Behavior and the Social Environment course had words like “life course,” “life stages,” “lifecycle,” or “lifespan” in its course description, then it was counted in the Lifespan Development category, otherwise it was placed in the Other Development category. Finally, some of the CSWE courses did not fit into any of the categories so they were placed in the Other category. Many of these courses were integrative seminars.

Course syllabi. Course syllabi were analyzed by sorting the syllabi into the same categories used in the analysis of the program curricula. For each category, frequency counts were made of each required textbook listed on the syllabi. Recommended and supplemental textbooks as well as journal articles and chapters from books in a class reader were not included. No syllabi were requested in the categories of Antisocial Behavior, Child Placement, Child Group Therapy, Practice, and Other, because no courses in these categories were offered by the programs.

Accreditation standards. The accreditation standards of COAMFTE, CACREP, and CSWE Commission on Accreditation (Commission on Accreditation of Marriage and Family Therapy Education, 1997; Council for Accreditation of Counseling and Related Education Programs, 1994; Council on Social Work Education Commission on

Accreditation, 1994a, 1994b) were analyzed by looking for references to any curriculum related to children or development, practicum and internship experiences involving young children, facilities for counseling and therapy with young children and families with young children, and the qualifications of faculty.

Constant Comparative Method

Grounded theory is a general method for the discovery of theory from the data (Glaser & Strauss, 1967; Strauss & Corbin, 1994). Grounded theory techniques are a form of inductive analysis in that themes, categories, and patterns emerge out of the data rather than being imposed on them prior to the data collection and analysis (Patton, 1990).

The constant comparative method is a grounded theory technique of analysis that, in this study, was utilized on the responses to the open-ended questions of the survey questionnaires and the expert interviews and on the quotations from the research and clinical literature. This method was used to answer research questions one, two, and three. As Strauss (1987) stated, one uses the constant comparative method by coding “from interviews, field observations, and other documents including published material” (p. 63).

The constant comparative method of data analysis involved the following steps as described by Glaser and Strauss (1967), Lincoln and Guba (1985), and Strauss (1987). First, the data was initially coded by identifying major themes, categories, and concepts in the responses and quotations. This coding is referred to as open coding (Strauss). Second, as the data was read and reread themes, categories, and concepts that emerged were compared across the data and with categories and concepts that had previously

emerged. This process allowed the concepts and categories to be further refined. Throughout this process, theoretical memos were used to describe the relationship between concepts and categories.

The analysis was completed when no new core categories emerged from the data and when additional analysis resulted in nothing new being added to the categories. This process is referred to as theoretical saturation (Glaser & Strauss, 1967; Strauss, 1987). Analysis was also concluded when all sources were exhausted, there was a sense of integration of the categories, and any new information was far removed from the present categories (Lincoln & Guba, 1985).

Recommendations for Training

Recommendations for training family counselors and therapists to work with young children and families with young children were developed by comparing the results of the description and structure of current training as described and measured by the program curricula, survey questionnaires, course syllabi, and accreditation standards to the results of the prescription for training in order to work with young children and families with young children suggested by the research and clinical literature and the expert interviews.

Reliability and Validity of Study

In qualitative research, “there are no straightforward tests for reliability and validity” (Patton, 1990, p. 372). Instead one looks at the trustworthiness of the study which includes credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). The credibility of a study depends on careful and rigorous methods for gathering and analyzing high-quality data; the skill, competence, training, and experience of the

researcher; and the researcher's philosophical belief in and appreciation of qualitative research (Patton). Credibility also involves triangulation, peer debriefing, negative case analysis, and referential adequacy (Lincoln & Guba).

Triangulation consists of the use of multiple methods of data collection and analysis from multiple sources utilizing multiple researchers and multiple theoretical perspectives (Denzin, 1978; Patton, 1990). Multiple methods of data collection allow one to look for consistency of data across sources. The different perspectives of multiple researchers with varying backgrounds limits the potential bias of only one researcher (Guba, 1981). Triangulation allows the research to be more reliable and valid through the researcher comparing and cross-checking the consistency of the data on an ongoing basis (Patton; Morse, 1994). The present study involved triangulation through the use of six kinds of data collection, two forms of data analysis, and the research team.

Peer debriefing involves meeting with a peer who inquires about unexplored aspects of the data collection or analysis. Negative case analysis consists of refining hypotheses made about the data until they can account for all known cases. Referential adequacy refers to the archival of some of the data in order to be analyzed by others at a later date (Lincoln & Guba, 1985). The present study utilized peer debriefing, negative case analysis, and referential adequacy.

Transferability of a study's findings is accomplished by providing a thick description of the data that allows others to decide whether the results can be generalized to a particular group. The researcher provides the data while readers of the study's results

judge whether the findings are transferable (Lincoln & Guba, 1985). The results of this study are presented in Chapter III and in the Appendices.

The dependability of a study is established through an inquiry audit in which a qualified person outside the study examines the process of data collection and analysis and the results of the study (Lincoln & Guba, 1985). The research is valid if an explanation of the data fits the description of the data (Janesick, 1994). For the present study, an individual experienced in qualitative research reviewed the data collection and analysis to insure a rigorous procedure.

Finally, the researcher kept an audit trail and a reflexive journal in order to accomplish confirmability of the study. The audit trail includes the raw data and any notes or materials used in the data collection and analysis. A reflexive journal can include the logistics of the study, a personal diary, or a log of the study's procedures and methods (Lincoln & Guba, 1985). The present study utilized a journal containing the logistics of the study.

The reliability and validity of the design of survey questionnaires and expert interviews was established through the use of the multiple texts on survey design, focus groups, and pretesting. In addition, precontacts and follow-ups insured the highest response rate possible. The response rates for the surveys and expert interviews were 60% and 65%, respectively. These response rates were deemed adequate by the primary investigator's graduate faculty committee.

CHAPTER III

RESULTS AND DISCUSSION

This chapter presents the results of the analysis of the six types of data collected to answer the five research questions. Also included is a discussion of the results, limitations of the study, recommendations for training, and recommendations for future research.

Results

The results of this study are presented by type of data collected. The types of data include program curricula, survey questionnaire, course syllabi, accreditation standards, research and clinical literature, and expert interviews.

Program Curricula

Table 1 presents the percentage of programs by program type with a required or elective child-related course in each course category. The greatest percentage of programs had required courses in the Lifespan Development category. This was true for all three program types. For the COAMFTE programs, the Family Development and Other Development categories were tied for having the second most programs with a course in these areas. For the CACREP programs, Parent-Child Relationships was second and Other Development was third. For the CSWE programs, Child Policy & Services was second and Other Development was third.

Concerning the elective courses, the Other Development category had the most COAMFTE programs with a course in this area. Child Assessment and Parent Education were tied for having the second most COAMFTE programs with a course in these areas. For the CACREP programs, Child Psychotherapy and School Therapy were tied for having the most programs with a course in these areas, while Other Development was third. For the CSWE programs, School Therapy and Practice were tied for first, while Child Abuse and Child Psychotherapy were tied for third.

Table 1

Percentage of Programs with a Required or Elective Child-Related Course by Course Category and Program Type

Course Category	Program Type					
	COAMFTE n=43		CACREP n=20		CSWE n=67	
	Req	Elect	Req	Elect	Req	Elect
Lifespan Development	50	7	95	0	61	1
Family Development	36	2	10	0	12	1
Other Development	36	33	20	20	39	4
Parent-Child Relationships	7	16	25	0	0	1
Child Psychopathology	5	5	5	5	4	13
Child Assessment	2	18	0	5	3	3
Child Abuse	7	7	0	15	4	25
Antisocial Behavior	0	0	0	0	0	3
Child-Related Laws	0	5	5	5	3	6
Child Policy & Services	0	11	0	0	48	21

Child Placement	0	0	0	0	0	7
Cultural Influences on Children	5	14	5	5	0	0
Special Populations	0	2	0	10	1	13
Parent Education	7	18	10	15	0	1
Child Psychotherapy	9	5	15	45	13	25
Play Therapy	0	7	5	10	0	7
Family Play Therapy	0	2	0	0	0	0
Child Group Therapy	0	0	0	0	0	1
Parent-Child Therapy	7	0	10	0	0	0
Family Therapy with Children	11	0	10	0	0	0
School Therapy	0	5	5	45	1	42
Practice	0	0	0	0	22	42
Other	0	0	0	0	15	21

Note. Students may not have taken all the required courses, because some programs

allowed students to choose between required courses. Some elective courses may not have been taken by any of the program's students.

Req = Required; Elect = Elective.

Table 2 displays the mean number of required and elective courses per program by program type. The CACREP and CSWE programs had the largest mean number of required child-related courses per program. The CSWE programs had the greatest mean number of elective courses per program.

Table 2

Mean Number of Child-Related Courses Per Program

Program Type	Course Type		
	Required	Elective	Total
COAMFTE ^a	1.8	1.7	3.5
CACREP ^b	2.4	2.1	4.4
CSWE ^c	2.4	2.8	5.1

Note. Students may not have taken all the required courses, because some programs allowed students to choose between required courses. Some elective courses may not have been taken by any of the program's students.

^an = 43. ^bn = 20. ^cn = 67.

Table 3 portrays the percentage of programs with no required or elective child-related courses by program type. The COAMFTE and CACREP programs had the largest percentage of programs with no required child-related courses, while the COAMFTE programs had the greatest percentage of programs with no elective child-related courses. Almost half of the COAMFTE programs had no child-related electives.

Table 3

Percentage of Programs with Zero Child-Related Courses by Program Type

Program Type	Course Type	
	Required	Elective
COAMFTE ^a	5	49
CACREP ^b	5	15
CSWE ^c	1	15

^an = 43. ^bn = 20. ^cn = 67.

Survey Questionnaire

A total of 62 surveys were sent to program directors. Thirty-seven or 60% were filled out and returned. Five or 8% of the program directors responded to follow-ups by stating that they would not fill out the survey.

Courses and Instructors

Table 4 shows the percentage of child-related elective courses by the percentage of students who take the courses (0%, 1 to 25%, 26 to 50%, and 51 to 99%) and by program type. Most of the COAMFTE elective child-related courses were taken by no students. Most of the CACREP elective child-related courses were taken by 1 to 25% of the students.

Table 4

Percentage of Elective Child-Related Courses by Percentage of Students Who Take the Course and by Program Type

% Students Who Take Course	Program Type		
	COAMFTE	CACREP	Total
0%	52	0	38
1-25%	22	67	33
26-50%	8	28	13
51-99%	4	6	4
100%	16	0	12

Note. Percentages may not add to 100 due to rounding.

Table 5 presents the percentage of child-related elective courses offered at various times (every semester, twice a year, once a year, every other year, and as needed) by program type. Most electives in both program types were offered once a year.

Table 5

Percentage of Child-Related Elective Courses Offered at Various Times by Program Type

How Often Course Is Offered	Program Type		
	COAMFTE	CACREP	Total
Every semester	5	0	3
Twice a year	11	11	11
Once a year	43	72	52

Every other year	7	6	6
As needed	34	11	27

Note. Percentages may not add to 100 due to rounding.

Table 6 displays the percentage of instructors for the child-related courses with clinical and teaching experience in the ranges of years including 0 to 5, 6 to 10, 11 to 15, 16 to 20, 21 to 25, and 26 and above and by program type. First of all, concerning clinical experience, most instructors in the COAMFTE programs had 0 to 5 years experience. In the CACREP programs, the greatest percentage of instructors had 11 to 15 years of experience. For teaching experience, the largest percentage of COAMFTE instructors had 11 to 15 years of experience, while most CACREP instructors had 6 to 10 years of experience.

Overall for both program types, most instructors had little clinical experience (0 to 5 years) and a moderate level (11 to 15 years) of teaching experience.

Table 6

Percentage of Instructors for Child-Related Courses with Various Clinical and Teaching Experience by Program Type

Experience in Years	Program Type					
	COAMFTE		CACREP		Total	
	C	T	C	T	C	T
0-5	49	19	15	12	37	17
6-10	17	11	20	32	18	17
11-15	20	39	23	8	22	30
16-20	9	20	18	20	11	18

21-25	3	7	13	12	7	9
26+	2	4	13	16	6	8

Note. Percentages may not add to 100 due to rounding.

C = Clinical; T = Teaching.

Practicum and Internship Sites

Table 7 portrays the percentage of practicum and internship sites that serve clients that are young children or families with young children by program type. The CACREP programs had a greater percentage of sites that see children and families with young children than the COAMFTE programs, but the difference was small.

Table 7

Percentage of Practicum and Internship Sites that Serve Clients that are Young Children or Families with Young Children by Program Type

Program Type	Percentage
COAMFTE	75
CACREP	79
Total	78

On-Campus Clinic

Table 8 shows the mode, median, and mean percentage of clients that are young children or families with young children in the on-campus clinics of the COAMFTE programs, the CACREP programs, and both programs combined. Both types of programs had a mode of 60%, but the COAMFTE programs' distribution was bimodal. The CACREP programs had the greater median and mean percentage of clients who are

young children or families with young children. All the directors did report that their on-campus clinics see young children or families with young children.

Table 8

Mode, Median, and Mean Percentage of On-Campus Clinic Clients that are Young Children or Families with Young Children by Program Type

Program Type	Measure of Central Tendency		
	Mode	Median	Mean
COAMFTE	25, 60	33	40
CACREP	60	35	44
Total	25, 60	31.5	41

Table 9 presents the percentage of COAMFTE, CACREP, and combined programs who have toys in the waiting rooms of their on-campus clinics. The COAMFTE programs had the greater percentage of waiting rooms with toys.

Table 9

Percentage of Programs with Toys in On-Campus Clinic's Waiting Room by Program Type

Program Type	Percentage
COAMFTE	77
CACREP	60
Total	71

Table 10 displays the percentage of counseling/therapy rooms that are child-related by type of facility (play therapy room, sandtray therapy room, and activity therapy room) and by program type. Both program types had similar percentages of play therapy rooms

and sandtray therapy rooms. The CACREP programs had a greater percentage of activity therapy rooms.

Table 10

Percentage of Counseling/Therapy Rooms that are Child-Related by Type of Facility and Program Type

Program Type	Facility Type		
	Play	Sand	Activity
COAMFTE	14	5	6
CACREP	14	5	23
Total	14	5	10

Note. Play = play therapy room; Sand = sandtray therapy room; Activity = activity

therapy room.

Table 11 portrays the percentage of child-related facilities in the on-campus clinics used to see young children individually and used for family counseling/therapy by program type. All programs in both program types used the child-related facilities for family counseling/therapy, while the COAMFTE programs had the greater percentage of programs using the facilities to see children individually.

Table 11

Percentage of Child-Related Facilities by Use and Program Type

Program Type	Use	
	Individual	Family
COAMFTE	77	100
CACREP	70	100
Total	74	100

Note. Individual = Young Children Seen Individually; Family = Family Counseling/

Therapy.

Table 12 shows the percentage of child-related resources (toys, art supplies, and bibliotherapy books) in each type of program that are available for students to bring into a counseling or therapy room for family counseling/therapy sessions. All programs in both program types had toys available for the students. All the COAMFTE programs had art supplies and bibliotherapy books for their students to utilize.

Table 12

Percentage of Child-Related Resources Available to Students by Type of Resource and Program Type

Program Type	Type of Resource		
	Toys	Art	Books
COAMFTE	100	100	100
CACREP	100	90	90
Total	100	97	97

Note. Art = Art supplies; Books = Bibliotherapy books

Experiential Activities

Table 13 presents the percentage of programs that require various experiential activities of their students by program type. The CACREP programs had the greater percentage of programs that require observation of normal or non-client children, play therapy sessions, and family counseling/therapy sessions with young children; watching videotapes of play therapy sessions and family play therapy sessions; and doing play therapy sessions with “normal” or non-client children and family play therapy sessions with “normal” or non-client families and with client families. The COAMFTE programs had the larger percentage of programs that require their students to do play therapy sessions with client children.

Overall, observing family counseling/therapy with young children was the most required activity. The lowest percentages were for the activities that involved “normal” children or families.

Table 13

Percentage of Programs that Require Various Experiential Activities by Program Type

Experiential Activity	Program Type		
	COAMFTE	CACREP	Total
Observe “normal” children	48	67	54
Observe play therapy	50	56	53
Observe family counseling/therapy with young children	88	100	91
Watch videotape of play therapy	54	56	56
Watch videotape of family play therapy	54	78	62

Do play therapy with “normal” children	27	33	29
Do play therapy with client children	62	44	58
Do family play therapy with “normal” family	19	33	24
Do family play therapy with client family	50	56	53

Satisfaction with Program

Table 14 displays the mode, median, and mean ranking of satisfaction with how well the program prepares its students to work with young children and families with young children by program type. Satisfaction was ranked on a scale from one to five with one being unsatisfied and five being very satisfied. The COAMFTE programs had the greater median and mean satisfaction ranking. Both programs had a mode satisfaction ranking of four, but the CACREP programs’ distribution was bimodal.

Table 14

Mode, Median, and Mean Ranking of Satisfaction with Program by Program Type

Program Type	Measure of Central Tendency		
	Mode	Median	Mean
COAMFTE	3, 4	4	3.6
CACREP	1, 4	3	2.8
Total	4	3	3.4

Note. Ranking is from 1 to 5 with 1 being unsatisfied and 5 being very satisfied.

Beliefs

Table 15 portrays the percentage of program directors who agreed with each of the following statements: (1) All students should be required to take the same core child-

related courses (generalist approach)., (2) Electives should be available for students who really want to focus on family counseling/therapy with young children (specialization approach)., (3) Accreditation standards should be changed to require more core child-related courses., (4) Accreditation standards should be changed to include more electives for students who really want to focus on family counseling/therapy with young children., and (5) Accreditation standards should remain the same. More of the CACREP program directors agreed with the generalist approach and with the specialization approach and agreed that there should be more electives. More of the COAMFTE program directors agreed that accreditation standards should remain the same and agreed that there should be more core child-related courses. Overall for both program types, more directors agreed with a specialization approach than a generalist approach, and most believed standards should not change.

Table 15

Percentage of Program Directors Who Agreed with Statements Regarding Generalist vs. Specialization Approach and Changes to Accreditation Standards

Course Category	Program Type		
	COAMFTE	CACREP	Total
Generalist approach	56	89	64
Specialization approach	85	89	86
More child-related courses	29	25	28

More electives	33	38	34
Remain the same	54	50	53

Note. Directors may have agreed with more than one statement.

Course Syllabi

Table 16 shows the number of syllabi that were received and requested and the percentage of syllabi received in each course category. Overall, the percentage of syllabi received was small and ranged from 0% to 100% with a mode of 0%, a median of 19%, and a mean of 23%. As one program director wrote, “Instructors are reluctant to release syllabi.” Still another wrote, “I’m too busy to track down these syllabi.” No syllabi were received in the Child Psychopathology, Child-Related Laws, Child Policy & Services, Cultural Influences on Children, Special Populations, and Family Therapy with Children categories. Therefore, the course information provided below may not be representative of all courses in these categories.

Table 16

Syllabi Received by Course Category

Course Category	Number Received	Number Requested	Percentage
Lifespan Development	13	46	28
Family Development	4	19	21
Other Development	15	63	24
Parent-Child Relationships	3	16	19
Child Psychopathology	0	6	0
Child Assessment	1	11	9
Child Abuse	1	10	10

Child-Related Laws	0	4	0
Child Policy & Services	0	4	0
Cultural Influences on Children	0	11	0
Special Populations	0	3	0
Parent Education	4	18	22
Child Psychotherapy	7	20	35
Play Therapy	1	6	17
Family Play Therapy	1	1	100
Parent-Child Therapy	4	4	100
Family Therapy with Children	0	7	0
School Therapy	3	13	23

Appendix N shows a list of required textbooks used by two courses in the categories of Lifespan Development, Family Development, Other Development, Child Psychotherapy, and Parent-Child Therapy. The Lifespan Development and Parent-Child Therapy had the greatest number of textbooks used by two courses. Appendix O presents a list of required textbooks for each category used by only one course. This table reflects the great diversity of textbooks used in various courses. There were no textbooks required by more than two courses.

Accreditation Standards

The results from the analysis of the accreditation standards of COAMFTE, CACREP, and CSWE Council on Accreditation (Commission on Accreditation of Marriage and Family Therapy Education, 1997; Council for Accreditation of Counseling and Related

Education Programs, 1994; Council on Social Work Education Commission on Accreditation, 1994a, 1994b) are presented here by the following types of references found in the standards: curriculum related to children or development, practicum and internship experiences involving young children, facilities for counseling and therapy with young children and families with young children, and the qualifications of faculty.

Curriculum

COAMFTE's standards require two courses in an area called "Individual Development and Family Relations" that includes "significant material on individual development...family development and family relationships." (Commission on Accreditation of Marriage and Family Therapy Education, 1997). The standards did not state more specifically what this material entails.

CACREP's standards require a common core area called "Human Growth and Development." This area includes

- a. theories of individual and family development and transitions across the life-span;
- b. theories of learning and personality development; c. human behavior including an understanding of developmental crises, disability, addictive behavior, psychopathology, and environmental factors as they affect both normal and abnormal behavior; d. strategies for facilitating development over the lifespan; and e. ethical considerations. (Council for Accreditation of Counseling and Related Education Programs, 1994)

Its standards also stated particular requirements for marriage and family counseling/therapy programs including students having knowledge and skill in family

life-cycle developmental stages and preventive approaches for working with families such as training in parenting skills.

CSWE Commission on Accreditation's Curriculum Policy Statement describes a professional foundation curriculum in an area called "Human Behavior and the Social Environment." This area involves

content about theories and knowledge of the human bio-psycho-social development, including theories and knowledge about the range of social systems in which individuals live (families, groups, organizations, institutions, and communities). The human behavior and social environment curriculum must provide an understanding of the interactions among human biological, social, psychological, and cultural systems as they affect and are affected by human behavior. The impact of social and economic forces on individuals and social systems must be presented. Content must be provided about the ways in which systems promote or deter people in maintaining or achieving optimal health and well-being. Content about values and ethical issues related to bio-psycho-social theories must be included. Students must be taught to evaluate theory and apply theory to client situations. (Council on Social Work Education Commission on Accreditation, 1994a)

Taken together, all three accrediting bodies require coursework on human development, but none of the standards described material specifically using the word "children."

Practicum and Internship Experiences

Section 400.08 of COAMFTE's standards states, "Students will have the opportunity to work with clients who are diverse in terms of age, culture, ethnicity, gender, race, religion, sexual orientation and socioeconomic status."

Section III L of CACREP's standards asserts, "Clinical experiences (practicum and internship) provide opportunities for students to counsel clients representative of the ethnic, lifestyle, and demographic diversity of the community."

Section M5.0 of CSWE's Commission on Accreditation Curriculum Policy Statement maintains, "All master's social work programs must: Provide content about social work practice with client systems of various sizes and types. Prepare graduates to practice with diverse populations."

All three organizations described a requirement that students have an opportunity to work with diverse populations. One might assume that this diversity includes young children.

Facilities

None of the standards included any statements regarding specific facilities to support family counseling/therapy with young children.

Faculty

Section 130.07 of COAMFTE's standards states, "Faculty will have training, experience, and a demonstrated ability in teaching the material that is their responsibility."

Section IV H of CACREP's standards asserts, "Program faculty members are assigned to provide classroom and clinical instructional services only in areas for which they have demonstrated competence."

Section 4.0 of CSWE Commission on Accreditation Master's Evaluative Standards and Interpretive Guidelines (1994b) maintains

The program must have full-time faculty adequate in number, qualifications, competence, and range of expertise to achieve its goals...Range of expertise is based on educational background, teaching and educational administrative experience, and experience in professional practice.

All three standards called for the faculty to have educational, clinical, and teaching experience or competence in the areas in which they teach.

Research and Clinical Literature

Qualitative analysis of the quotations from the research and clinical literature resulted in four core categories called (a) General Information, (b) Self of the Therapist, (c) Knowledge and Skill, and (d) Communication. The General Information core category contained two categories called Program Features and Experience. The Self of the Therapist core category consisted of two categories entitled Attitudes and Characteristics. Within the Knowledge and Skill core category, eight categories emerged including Introduction, Child Therapy, Play Therapy, Child Development, Family Development, Child Psychopathology, Child Assessment, and Other Techniques. The Communication core category comprised two categories called Play and Verbalization.

General Information referred to general information and advice concerning program features and the experiential portion of the therapist's education. Self of the Therapist was chosen as a core category, because this category described the attitudes and characteristics the therapist should have. Knowledge and Skill consisted of knowledge and skills family therapists should have including child therapy, play therapy, child development, family development, child psychopathology, child assessment, and other techniques of including young children in family therapy. Communication comprised knowledge of children's ways of communicating through play and verbalization.

Table 17 depicts an historical analysis of the percentage of references by Core Category and by Category in the case of the Knowledge and Skill Core Category. No references were found prior to the 1970s. Most of these references, which described how family counselors and therapists should be trained to work with young children and families with young children, had been published from 1980 to 2000. The literature published in the 1980s mainly focused on the self of the therapist, child therapy, techniques, and communication. Contrastingly, the literature published in the 1990s primarily emphasized general information about programs, play therapy, child development, family development, and child psychopathology.

Table 17

Percentage of References by Decade and Category

Category	Decade		
	1970s	1980s	1990s-2000
General Information	0	44	56
Self of the Therapist	7	57	36

Child Therapy	0	57	43
Play Therapy	27	33	40
Child Development	17	26	57
Family Development	0	25	75
Child Psychopathology	25	25	50
Child Assessment	0	50	50
Other Techniques	29	43	29
Communication	27	55	18

Note. References may have more than one quotation in each category.

General Information

This core category includes general information and advice concerning program features and the experiential portion of the therapist's education.

Program features. Three articles made recommendations about the general features of a program. Keith and Whitaker (1981) advised that in the beginning of therapists' education, a "structured and strategic method of working" (p. 245) should be used with them, but they should later move away from a focus on technique. In addition, they stated, "theoretical structures act as platforms for expanding the experience component of therapy" (p. 245). Fauber and Kendall (1992) advocated an eclectic stance within programs so that students do not become overly specialized with either child-focused or family-focused interventions. Finally, Korner (1988) believed programs need "an optimum balance of personal and professional supports to facilitate work with children" (p. 112). By this he meant that programs should help therapists overcome their "personal fears and professional shortcomings" (p. 111) when it comes to working with children.

Experience. Several quotations referred to experiences students should have and ways to improve the experiential component of their education. “Undoubtedly, experiential training and supervision are essential for family therapists who want to include children in therapy” (Rober, 1998, p. 202) and the more experience, the better (Harvey, 1994). Therapists are more likely to include children in family therapy when they have had didactic and clinical experience working with children (Korner, 1988). Experience should “go beyond classroom instruction and role-plays, and instead involve direct interaction with mentally ill children and adolescents and their families, as well as provide the opportunity to observe professionals/supervisors working with this population” (Jordan, Excell, & Waggoner, 1999, p. 52). Experience should also involve observing normal families interacting, particularly in play, and seeing how the family members enter into a conflict and solve it. This observation will help the therapist know how to encourage clients to solve problems creatively (Harvey). Finally, two articles (Keith, 1986; Anderson & Reynolds, 1996) recommended that beginning therapists should have a cotherapist when seeing families with children. Live supervision teams should be used to provide families with the most helpful therapy (O’Brien & Loudon, 1985).

Self of the Therapist

This core category contains recommendations about the attitude and characteristics of the therapist.

Attitude. “Family therapists who want to work with children should prepare themselves for hard work” (Rober, 1998, p. 206). There are several things they should be aware of, reflect upon, and understand including one’s self and family of origin (Moss-

Kagel, Abramovitz, & Sager, 1989); one's ambivalent attitudes toward children; any propensity to undervalue children; whether one's attitudes fall within an open-minded or restrictive philosophy (O'Brien & Loudon, 1985); one's anxieties, hesitations, and vulnerabilities (Rober); and all one's personal information about children including one's own childhood, own children, and friends' children and experiences of children in novels, movies, and public places (Combrinck-Graham, 1985). This is important because "unconsciously held attitudes are likely to influence therapy, so the more therapists understand their own reactions to children's behaviour and the attitudes behind them, then the greater will be their understanding of children and the more effective their therapy" (O'Brien & Loudon, p. 85). Understanding one's reactions to children can also increase empathy and understanding of the whole family (Scholfield-MacNab, 1989). One way to reflect on one's attitudes is to examine changing attitudes toward childhood throughout history (O'Brien & Loudon). However, "gaining knowledge from lectures, articles, and even good books or plays, does not automatically overcome strongly developed adult attitudes and feelings" (Zilbach, 1986, p. 20).

Finally, the therapist needs to be able to play with families with young children (J. S. Scharff, 1989), help them play together (Kaslow, Smith, & Croft, 2000), and to view play as child's work (Zilbach, 1982) in order to include young children in family therapy. Reading about play may help overcome any unwillingness to include children in therapy (Zilbach, 1986).

Characteristics. Several articles described characteristics a therapist who wants to work with children should have. "Therapists who are interested in children, able to

express warmth and connection to them, and willing to operate, at least in part, in the child's world, will likely have more success involving children in therapy" (Stith, Rosen, McCollum, Coleman, & Herman, 1996, pp. 84-95). Therapists who work with children are people "who are amused and energized by them, whose sensibilities are enlarged by the young, and who are reasonably at peace with their special way of ordering and relating to things and people" (Bloch, 1976, p. 172). The therapist should be creative (Harvey, 1994), flexible, and playful when relating to children (Cordell & Allen, 1997). He or she should

have security and trust in his or her human and professional abilities to engage in interactions in which strong intimacy and affect are being expressed, negotiated, and defended against, even if only in a playful manner. Without such trust and security, the therapist may be tempted to stop, redirect, or offer boundaries that are so rigid that families are unable to truly explore creative options. (Harvey, p. 95)

The therapist should also be tolerant of the vacillation of progression and regression as part of normal child development (Gordetsky & Zilbach, 1989) and be tolerant of uncertainty, chaos, and confusion, and be aware that one "won't be able to control or understand everything in the session" (Rober, 1998, p. 206). Finally, intimacy, nurturance, and responsiveness are more important than emotional differentiation when working with families with young children (Combrinck-Graham, 1985).

Knowledge and Skill

This core category describes knowledge and skills family therapists should have including child therapy, play therapy, child development, family development, child

psychopathology, child assessment, and other techniques of including young children in family therapy.

Introduction. “The treatment of childhood disorders involves more than simply the education, counseling, or treatment of parents...Specialized attention and skill need to be paid to the disturbed child in order to understand and to treat him and his problems” (McDermott & Char, 1974, p. 429). Young children can only be effectively included in family therapy by “genuine child and family experts” (p. 435). Therapists should know a wide range of techniques to use with children so they can deal effectively with a wide range of situations (O’Brien & Loudon, 1985). Beginning therapists can become overwhelmed by the significant body of knowledge required of them. “We have no therapists if immediate mastery were a requirement. Becoming a therapist is a lifelong, dynamic process of development” (Moss-Kagel et al., 1989, p. 124).

Child therapy. Seven references recommended training in child therapy with one asserting that qualifying examinations for licensure should consist of material from this area (Nickerson, 1986). More specifically, therapists should know “how to communicate in the child’s language or take the further step of showing the parents how to do the same” (Guerney & Guerney, 1987) and how to engage a child in a helping relationship (Carr, 1994). They should also be able to understand child’s play (Zilbach, 1989) and use culturally competent intervention techniques (Kaslow, et al., 2000).

“Child training teaches the therapist to tap the richness of the child’s contribution and to use it in the process of family treatment as well” (Gordestky & Zilbach, 1989, p. 102).

In addition, knowledge and skill in child therapy also allows one to be able to tell parents that one can do child therapy (Kuehl, 1993) and permits one to know how to include children in therapy (Carr, 1994). Benson, Schindler-Zimmerman, and Martin (1991) warned, however, “knowledge of child therapy techniques may foster separate therapy sessions with the child and parents” (p. 364) rather than techniques that include children in family sessions.

Play therapy. Fifteen references advised training in play therapy. Family therapists can profit from training and application in play therapy when working with children (Guttman, 1975; Nickerson, 1986) and in family play therapy (Stith, et al., 1996). According to one article, training in play therapy is “essential to the therapist working with families” (Gordetsky & Zilbach, 1989, p. 97). Family play therapy, in particular, requires training and experience in play therapy (Eaker, 1986; Griff, 1983; Hardaway, 1990; Stoddard, Wilberger, & Olafson, 1993). Play in family therapy is used to assess, communicate, and effect change. “The latter application requires understanding of the therapeutic power of play” (Ariel, 1996, p. 6). One can “observe and interpret the play, and also allow the child to retreat into it if he is not ready to deal with particular issues” (McDermott & Char, 1974, p. 433). More specifically, training in play therapy allows one to “facilitate appropriate play at the developmental level of the youngest individual” (Hardaway, p. 141) in the family, to “tap the rich psychic life of children” (McDermott & Char, p. 433), and correctly interpret the child’s use of play material (Zilbach, Bergel, & Gass, 1972).

A therapist trained in play therapy can better “adapt therapeutic goals, techniques, and the way he/she uses himself/herself to the needs and styles of different families” (Rosenbaum & Serrano, 1979, p. 78) and can “relate to families in a flexible, responsible way” (p. 80). Training in play therapy also “prepares the clinician for the process aspects involved in using expressive activities” (Harvey, 1994, p. 93) with families.

Play therapy is learned mainly by experience (Keith & Whitaker, 1981). Therefore, family therapy programs should consider requiring students to have supervised individual play sessions with clinical and nonclinical children (Stith et al., 1996). The “hands-on experience with children in play therapy provides valuable skills in relating to young people in family therapy, as well as an increased awareness of relationship issues and therapeutic process” (Larner, 1996, p. 424).

Two authors, contrastingly, stated that one does not need to be fully trained in play therapy in order to focus on play in family sessions (D. E. Scharff, 1989). “Since the child is already an expert at play and, given a simple invitation, will go a long way; the adult merely has to be willing to tag along and take up the meanings that emerge” (Freeman, Epston, & Lobovits, 1997).

Child development. Twenty-three references proposed knowledge of child development. This knowledge is “crucial” (Malone, 1979, p. 7) and “essential” (Gordetsky & Zilbach, 1989, p. 97) to the family therapist. Several references recommended that family therapists be familiar with child development (O’Brien & Loudon, 1985; Moss-Kagel, et al., 1989; Kaslow, et al., 2000). One training model proposed a course entitled “Child Development in Family Context” (Garfield, 1979).

Family play therapy, in particular, requires an understanding of child development (Miller, 1994).

The therapist should know the developmental needs (Minuchin, 1974), stages (Levant & Haffey, 1981), norms (Combrinck-Graham, 1985), and issues (Hardaway, 1990) of children of different ages and how to respond to them (Kaslow & Racusin, 1990). The therapist should also know how developmental issues translate into practice (Ruble, 1999) and what comprises healthy child development (Taffel, 1999). “Much of the behavior that parents find troublesome is transient. Children who are developing normally go through phases that are dominated by certain issues and behaviors” (Zilversmit, 1990, p. 218). In addition, “at each developmental stage, children have different styles of relating to others and different requirements of how others should relate to them” (Taffel, 1991, p. 40). One should know “what a child is capable of cognitively understanding, feeling, and mastering behaviorally at any stage of development” (Selekman, 1997, p. 211).

Knowledge of child development provides a “fuller understanding of family life” (Anthony, 1973, p. 7); helps one understand children’s play (Zilbach, 1989), know how to include children in therapy (Carr, 1994), and know how to communicate with the child and design and selecting therapeutic tasks (Selekman, 1997); assists one in educating parents on what to expect at each developmental stage, in normalizing the child’s behavior, and helping them “find the right ‘keys’ or course of action for supporting their children’s mastery of developmental tasks” (p. 23); helps one “adapt to the world of the

child” (Rober, 1998, p. 207); and informs the choice of appropriate play material (Scott, 1999).

Even more specifically, “without understanding individual temperament and family fit” the therapist “can miss, or misinterpret, vital information about family functioning as a whole” (Diller, 1991, p. 22). Also, “failing to recognize inherent developmental delays in learning, language and motor skills in a child can do real harm” (p. 25).

Family development. Four references advocated knowledge of family development. Knowledge of family development (Kaslow, et al., 2000) or the family life cycle helps the therapist assess the family and know the normative issues of the stage of the family (Moss-Kagel, et al., 1989). Family therapists should know how family developmental issues translate into practice (Ruble, 1999). Family play therapy, in particular, also requires an understanding of family development (Miller, 1994).

Child psychopathology. Four references suggested knowledge of child psychopathology. Family therapy requires knowledge of developmental psychopathology (Kaslow, et al., 2000). This knowledge includes “understanding how children develop difficulties during the course of their growing up and how these difficulties are expressed...as related as much to the family context as to pathological processes within the child” (Combrinck-Graham, 1985, p. 21). One program described a one-day workshop in which participants learned about symptomatology and medications used with children (Jordan, et al., 1999) while another training model recommended a course entitled “Child Psychopathology in a Family Context” (Garfield, 1979).

Child assessment. Two references recommended knowledge of child assessment.

Family therapy requires knowledge of culturally competent child assessment (Kaslow, et al., 2000). Qualifying examinations for licensure should contain material on child assessment (Nickerson, 1986).

Other techniques. Seven references describe other skills and techniques family therapists should have. Family therapists should “be familiar with the range of nonverbal and action-oriented techniques and psychoeducational approaches for working with families with young children” (Kaslow, et al., 2000, p. 203). Techniques of including children in family therapy consist of rituals, games, family puppetry, kinetic family drawings, family art therapy, and metaphor (Benson, et al., 1991). The ability to use fantasy (McDermott & Char, 1974) in diagnosis and treatment is “crucial to the conduct of family therapy” (Malone, 1979, p. 7). Family therapists should also know how to access communication through fantasy, drawing, music, rhythm, and movement (Combrinck-Graham, 1985) and know how to keep children under control during sessions (Gordetsky & Zilbach, 1989). In addition, family therapists should know the technique of storytelling (McDermott & Char). Concerning children’s drawings, they need to recognize and include them in therapy, but they do not need “to know all about the intricacies of the characteristics of the developmental level of the children’s drawings” (Zilbach, 1982, p. 66). Contrastingly, Combrinck-Graham (1991) asserted that no special techniques are needed to include children in family therapy. She believed that family therapy naturally focuses on action and behavior rather than verbal interaction, descriptions of behavior rather than questions about causes, and clear limits for conduct

in family therapy sessions, all of which are helpful when children are included in the session.

Communication

This core category involves knowledge of children's communication through play and verbalization.

Play. Family therapists should know how children communicate through play (Moss-Kagel, et al., 1989), how to "understand and use their contributions" (Guttman, 1975, p. 499), and how to access communication through play in therapy (Combrinck-Graham, 1985; Zilbach, 1982). This ability to understand and use play in diagnosis and treatment is "crucial to the conduct of family therapy" (Malone, 1979, p. 7). Therapists should also know the "symbolic significance of children's verbal and nonverbal activity" so one can show the adults in the family how to "understand and respond to the child's communications" (Guttman, p. 491). In addition, they need to "understand the child's nonverbal language and use of play to express fantasies, feelings, and conflicts, and be able to communicate with the child through the use of play" (Levant & Haffey, 1981, p. 139).

Verbalization. The ability to use children's verbalizations in diagnosis and treatment is "crucial to the conduct of family therapy" (Malone, 1979, p. 7). The family therapist should understand the "importance and meaning of the communications of children of all ages" (Dare & Lindsey, 1979, p. 268) and know how to communicate and talk with all ages in "negotiating and implementing the treatment plan" (Cordell & Allen, 1997; O'Brien & Loudon, 1985; Taffel, 1991). "It is helpful to be skilled in using verbal

approaches as well as nonverbal ones in families with young children” (Wolfe & Collins-Wolfe, 1983, p. 87).

Expert Interviews

A total of 23 expert interviews were sent. Fifteen or 65% were filled out and returned. Two or 9% of the experts responded to follow-ups by stating that they would not fill out the interview.

Demographics

Table 18 provides demographical information about the respondents. Most experts described their theoretical orientation as family systems or Adlerian. Most also described themselves as a play therapist or family therapist. Half stated they were counselor educators.

Table 18

Experts’ Demographics

Mean Years of Experience		Range of Years of Experience	
25	Clinical	9-50	Clinical
20	Teaching	5-50	Teaching

Theoretical Orientation

- 27% Family systems
- 27% Adlerian
- 20% Child/person-centered
- 20% Specific family systems model (Intergenerational/Bowenian, Internal family systems, Structural/Contextual)
- 7% Psychoanalytic
- 7% Integrated

Self Description

- 25% Child therapist
- 56% Play therapist
- 56% Family therapist
- 47% Both play therapist and family therapist

50% Counselor educator

40% Other (Child psychiatrist, Family play therapist, Family researcher, Marriage therapist, Parent educator/therapist, School counselor)

Note. Percentages add to more than 100% because some experts answered in more than one category.

Children's Role in Family Counseling/Therapy

In the interview, the first question asked the experts what role they believed young children should play in family counseling/therapy. Qualitative analysis of their responses revealed three categories: Active, Use Play, and In-Session Roles.

Active. Sixty percent of the respondents stated that young children should play an active role or should actively participate in family counseling/therapy. They should be included and be involved, directly and interactively, “in order to emphasize their important membership in the family system.” Two experts wrote that children are an “integral part” of the family therapy process or the family dynamic. “Without them, the therapist is seeing/working with the couple dynamics only.” As one expert declared, “Family therapists, who often refer to themselves as ‘systemic’ have absolutely no right to consider families or systems without actively involving children.” Two experts mentioned that children should be involved in all stages of the therapeutic process including assessment, diagnosis, treatment planning, and treatment. One expert asserted that children should be seen even when the presenting problem is not child-related, because, “a highly conflictual marriage, for example, can cause children to have problems.”

Contrastingly, two experts stated that children can benefit from their own therapy. “Children deserve therapy of their own rather than serving as catalysts for other family

members' therapy. This can be done by parallel therapy for children with the adult's therapy, filial therapy, or some conjoint family arrangement." One expert wrote that the child's therapy would take the form of play therapy.

Finally, two experts provided some warnings about including young children in family counseling/therapy. "Young children should not be exposed to traumatic situations...[and] should not be forced to talk and be a part of adult decisions." In addition, "really young children (2-3) usually distract from the flow."

Use play. Forty percent of the respondents mentioned that therapists should use play when including young children in family counseling/therapy. For instance, one expert stated, therapists should "take into consideration and plan for [children's] developmental level, especially the natural means of communication utilized by children which is play." "In order to maximize their participation emphasis should be less on verbal communication and more on symbolic communication and expression." In addition, "Therapists need to have offices equipped with play therapy toys and they need to be able to employ play and family therapy techniques to work with this age group." Through play, therapists can "get to know the concerns of the child," and "the child may provide his/her perspective of the family and is/her role in it."

In-session roles. Sixty percent of the respondents described roles young children play in the family therapy sessions. Children are "active contributors to family process." Because they are "keen observers of family dynamics," they "can be the best indicators of deeper family issues." Similarly, one expert stated that children "are the windows to the family due to their lack of inhibitions and their strong natural tendency or desire for

growth.” They often “deliver their messages in a clear simple fashion.” In particular, as one expert explained, “older young children can be counted on to really let me know what is going on in the family.” In this way, children play the role of the “explainer” in this family.

In addition, two experts stated that including young children in family counseling/therapy allows the therapist to observe family interactions and patterns. One may also “affect changes in family patterns through enactments involving young children.” Finally, experts described other children’s roles as “the family’s barometer,” “symptom bearer,” and “facilitator.”

Beliefs

Table 19 displays the percentage of experts who agreed with each of the following statements: (1) All students should be required to take the same core child-related courses (generalist approach)., (2) Electives should be available for students who really want to focus on family counseling/therapy with young children (specialization approach)., (3) Accreditation standards should be changed to require more core child-related courses., (4) Accreditation standards should be changed to include more electives for students who really want to focus on family counseling/therapy with young children., and (5) Accreditation standards should remain the same. More experts agreed with a generalist approach than a specialization approach. A very high percentage of the experts agreed that accreditation standards should be changed to include more core child-related courses.

Table 19

Percentage of Experts Who Agreed with Statements Regarding Generalist vs. Specialization Approach and Changes to Accreditation Standards

Statement	Percentage Agreed
Generalist approach	87
Specialization approach	67
More child-related courses	93
More electives	40
Remain the same	0

Note. Experts may have agreed with more than one statement.

Regarding these issues one expert wrote,

Unless all students are exposed to the possibilities and given opportunities to face preconceived hesitancies, their choices may be limited. In other words, I have seen ‘interest’ develop and indeed thrive after exposure to skills that build a sense of competence.

Course Material

Table 20 portrays the percentage of experts who recommended various course material to be taken by all students and by students in a specialty in working with families with young children. The following course material was recommended by more of the experts to be taken by all students: Lifespan Development, Family Development, Parent-Child Relationships, Child Abuse, Cultural Influences on Children, Parent Education, Family Play Therapy, Parent-Child Therapy, and Family Therapy with Children. Lifespan Development, Family Development, Parent-Child Relationships, and

Family Therapy with Children were recommended by a high percentage of experts to be taken by all students. The following course material was recommended by more of the experts to be taken by students in a specialty: Child Psychopathology, Child Assessment, Special Populations, Child Psychotherapy, Play Therapy, Child Group Therapy, and School Therapy.

Table 20

Percentage of Experts Who Recommended Course Material for All Students and for Students within a Specialty

Course Material	Student Type	
	All	Specialty
Lifespan Development	87	0
Family Development	87	0
Parent-Child Relationships	93	7
Child Psychopathology	27	67
Child Assessment	20	67
Child Abuse	71	21
Antisocial Behavior	40	40
Child-Related Laws	40	47
Cultural Influences on Children	60	40
Special Populations	20	67
Parent Education	53	20
Child Psychotherapy	40	53
Play Therapy	33	60

Family Play Therapy	60	33
Child Group Therapy	7	73
Parent-Child Therapy	60	33
Family Therapy with Children	87	13
School Therapy	0	73
Other (Filial therapy)	13	0
Other (Child development, Divorce and blended family issues, Ethical issues, Expressive therapies, Group counseling, or Know what school counselors do)	27	0

A few experts had comments regarding course material. “The topic of children needs to be discussed in various courses, not only those which are dedicated wholly to them.”

One expert stated that filial therapy should be taught as a model of family therapy.

Another advised that requiring all students to have play therapy training “would ensure family therapists are capable of working with a broad range of families.” Still another recommended course material on laws regarding child abuse and ethical issues

concerning children. One also said that parent education training is “a must!” Finally, one expert asserted that the use of good textbooks that cover much of the course material mentioned above would decrease the number of courses needed.

Experiential Activities

Table 21 shows the percentage of experts who recommended various experiential activities the students should undergo. The majority of experts (over 50%) recommended all the activities except those listed in the Other category.

Table 21

Percentage of Experts Who Recommended Various Experiential Activities

Experiential Activity	Percentage Recommended
Observe “normal” children	100
Observe play therapy	92
Observe family counseling/therapy with young children	100
Watch videotape of play therapy	77
Watch videotape of family play therapy	100
Do play therapy with “normal” children	67
Do play therapy with client children	77
Do family play therapy with “normal” family	67
Do family play therapy with client family	92
Other (do filial therapy)	13
Other (lead children’s groups or do attachment work)	13

Other Comments

Seven or 47% of the experts provided other comments about what they believed master’s level marriage and family counseling/therapy programs should be doing to educate their students to work with young children. Two mentioned supervision. For instance, “I feel it is unethical for the therapist to work with client families with whom they have not been trained and supervised,” and the “role of supervision essential.” Two experts stated that programs should help therapists with their comfort level in working with children. For example, “They should have sessions which aid students in decreasing their fear of children—the material provided by children is often uncomfortable.” Two

experts provided suggestions for the students. First, “Students gain a great deal from attending play therapy conferences.” Also, “It is important in my mind for master level students to be clear with what client population they prefer to work.”

Comments provided by two other experts covered other topics. First, I don’t see how one can call herself a ‘family’ therapist if she does not know how to work with young children. All of our major models in family therapy are designed to work with adults. We need theory and modalities that teach us how to work with all ages in families, especially young children.

Next, “What MFT students should receive and actually receive is profoundly different. I have little expectation for substantial changes soon.” Finally, in a letter, an expert who chose not to respond to the survey wrote

My strongest opinion is that academic programs don’t do well when it comes to training therapists to work with children, because academic programs are inclined to emphasize theoretical learning over experience. Working with children and multigenerational families is a clinical (learn-by-doing) skill.

Discussion of Results

This section includes a discussion of the results concerning current training, literature recommendations, and expert recommendations and a comparison of the current training with the literature and expert recommendations.

Current Training

Current training of family counselors and therapists was measured by examining program curricula, course syllabi, and accreditation standards and by obtaining information about programs from their directors.

Program Curricula

Analysis of the program curricula revealed that most of the COAMFTE, CACREP, and CSWE programs required courses in the area of Lifespan Development. This is not surprising, given that the accreditation standards from all three program types require coursework in human development. For the COAMFTE programs, the Family Development and Other Development categories were tied for having the second most programs with a required course in these areas. These results may reflect the fact that many of these programs are housed in departments called Human Development and Family Studies.

For the CACREP programs, the Child Psychotherapy and School Therapy categories were tied for having the most programs with an elective course in these areas. These results may point toward the reality that many of the CACREP programs also had school counseling programs.

For the CSWE programs, Child Policy & Services was the second most required course area while School Therapy and Practice were tied for having the most programs with an elective course in these areas. The CSWE programs also had the most courses in the categories of Child Placement and Other. These results reveal the breadth of social work programs in that they train students to work with young children in ways other than

just therapeutically through counseling. For instance, the courses in the categories of Child Policy & Services, Child Placement, and Practice teach students about problems, policies, programs and methods of intervention in the child welfare system.

The CSWE programs had the greatest mean number of child-related courses per program of all the program types. At first glance, one might conclude that CSWE program do a better job of training their students to work with young children. However, many social work child-related courses are not traditional therapy or intervention courses, e.g., Child Placement, Child Policy & Services, and Practice. In other words, CSWE programs train their students to work with young children in a variety of ways and contexts that may or may not involve counseling such as child welfare, child protective services, substitute care, adoption, residential treatment, schools, and medical services.

Most of the COAMFTE elective child-related courses were taken by none of the students, and most of the CACREP elective child-related courses were taken by only 1 to 25% of the students. The mean number of child-related courses per program in the three program types is actually an inflated number, then, when one takes into account the fact that not all the students took all the child-related required and elective courses available to them. This is probably not a function of how often these courses were offered, because most elective courses were offered once a year. One reason for the low percentage of students taking child-related elective courses may be that programs do not require students to take many electives to graduate in the first place. Therefore, many students may not have enough available electives to take child-related courses.

Finally, the results from the analysis of the course syllabi revealed a great variety of textbooks used in the child-related courses. This finding may be evidence of a large diversity of textbooks on the market. This outcome may also mean that the child-related course content in the programs is quite varied. A more detailed analysis of the content of child-related courses from a higher reception of syllabi than the present study could better answer this question.

Instructors

Analysis of the results showed that overall for both program types, most instructors had little clinical experience (0 to 5 years) and a moderate level (11 to 15 years) of teaching experience. These results may be difficult to interpret, because one does not know how the program directors understood clinical and teaching experience to mean. They may have rated all clinical experience or just child-related clinical experience. In addition, they may have rated just graduate-level teaching experience or any teaching experience regardless of age level.

Practicum and Internship Sites

The percentages of practicum and internship sites that serve clients that are young children or families with young children in the various programs were moderately high. One may conclude then, that students should know how to work with this population since they serve them. It is also encouraging that these types of sites are available to students.

On-Campus Clinics

Clientele. In contrast, the overall percentage of clients that are young children or families with young children in the on-campus clinics of the various programs was somewhat low. This dissimilarity may be due to differences in the nature and contexts of the practicum and internship sites and the on-campus clinics. For example, an internship site might be a school district where 100% of the clients are young children, whereas on-campus clinics serve more variety of clients.

Waiting rooms. The percentage of programs with toys in the waiting rooms of the on-campus clinic was moderately high. One would expect these percentages to be higher since all the on-campus clinics serve young children. Therefore, some clinics are not child-friendly or welcoming to young children.

Child-related facilities. The overall percentage of counseling/therapy rooms that are child-related (play therapy room, sandtray therapy room, and activity therapy room) was somewhat low. These results may be difficult to interpret, because one does not know how the program directors defined what constitutes a play therapy room, sandtray therapy room, or activity therapy room. For instance, one director wrote that their program has portable play therapy duffle bags but no play therapy rooms. The CACREP programs may have had a greater percentage of activity therapy rooms, because many of these programs also had school counseling programs.

A moderately high percentage of the programs used the child-related facilities to see young children individually. However, one does not know how the program directors interpreted seeing young children individually. This might mean that the child is

primarily seen individually or is seen individually on a periodic basis along with family sessions. Even so, this result is not surprising given that traditionally, family therapists do not see children individually. As one program director wrote, “Rarely does this fit the systemic paradigm.” However, Levant and Haffey (1981), Kuehl (1993), and Wachtel (1987, 1990, 1991, 1992, 1994) have purported the benefits to seeing children individually and have described how this can fit within a systemic perspective.

Child-related resources. All the programs had toys available for the students to bring into a counseling or therapy room for family counseling/therapy sessions. Almost all the programs had art supplies and bibliotherapy books for their students to utilize. These results are very encouraging. However, one does not know from the data what percentages of students actually utilize these resources. In addition, many students may not receive training in how to use these resources in that very small percentages of programs required their students to take a course in Child Psychotherapy, Play Therapy, or Family Play Therapy. In these courses the students would likely be taught how to utilize these resources with young children.

Experiential Activities

The CACREP programs had the greater percentage of programs that required observation of normal or non-client children, play therapy sessions, and family counseling/therapy sessions with young children; watching videotapes of play therapy sessions and family play therapy sessions; and doing play therapy sessions with “normal” or non-client children and family play therapy sessions with “normal” or non-client families and with client families. The COAMFTE programs had the larger percentage of

programs that required their students to do play therapy sessions with client children.

Again, the differences in these types of programs might reflect that many CACREP programs had school counseling programs.

Overall, about 50% of the programs required that their students observe play therapy, watch videotapes of play therapy, do play therapy with client children and do family play therapy with client families. This is contradictory in that very small percentages of programs required their students to take a course in Child Psychotherapy, Play Therapy, or Family Play Therapy. How is it that students can engage in these experiential activities without having the coursework to understand and know how to do these various modalities? Even so, this is a moderate amount of programs that required their students to engage in child-related experiential activities.

Program Satisfaction

The COAMFTE programs had the greater mean ranking of satisfaction (3.6 on a scale from 1 to 5) with how well their programs prepare students to work with young children and families with young children, whereas the CACREP programs had a mean ranking of 2.8. One cannot tell from the data why the directors rated their programs as they did. This difference seems inconsistent, because the CACREP programs had a greater percentage of Child Psychotherapy and School Therapy courses, activity therapy rooms in their on-campus clinics, and required child-related experiential activities.

In addition, almost 40% of the directors who ranked their programs as a four or a five had inconsistent rankings when one compares their rankings to the number of child-related courses offered and the amount of experiential activities required of the students.

Furthermore, in these programs anywhere from zero to two child-related courses were offered, very few experiential activities were required of the students, few if any child-related facilities were in their on-campus clinics, and one program did not even have toys in its waiting room. Possible reasons for their higher rankings might be having the need for social desirability and the belief that general systems concepts and principles are all students need to know to work with any client regardless of the developmental level and mode of communication of the population.

Beliefs About Curricula and Accreditation Standards

Overall for both program types, more directors agreed with a specialization approach than a generalist approach. This finding contradicts the result that programs did not offer many child-related electives that could be used as a specialty. However, a majority of directors agreed with both approaches. One director stated, “The generalist approach appears more pragmatic as most MFTs must work with a variety of clients and must therefore be prepared to work with children as needed.” Concerning child-related courses, another director wrote, “I think every family therapist should have a basic level of comfort and skill involving children in family sessions. So we require all MFT students to have common child-related courses.”

In addition, most directors agreed accreditation standards should not change. A follow-up is needed to discover why directors believed as they did. Comments by a few program directors might shed light on the reason. One director wrote,

Accreditation standards already restrict and control curriculum too much. Added requirements simply make the programs look more like they come from a cookie

cutter rather than unique programs that require creativity to develop and reflect the personality of the faculty and institution.

Likewise, another director commented, “Accreditation standards already fill the curriculum to the extent that little specialization can occur.” Another possible reason is in line with the family system’s concept of homeostasis: systems, in this case family counseling/therapy programs, resist change.

Accreditation Standards

In summary, the COAMFTE, CACREP, and CSWE accreditation standards do not currently require much child-related course material. The standards regarding experiential requirements seem to infer that students should know how to work with clients of various ages including young children. All three standards call for the faculty to have educational, clinical, and teaching experience or competence in the areas in which they teach.

Literature Recommendations

Experience. Many authors described the importance of students receiving a great deal of experiential training and supervision in working with children in family therapy (Harvey, 1994; Jordan, et al., 1999; Korner, 1988; Rober, 1998). Two references (Anderson & Reynolds, 1996; Keith, 1986) advised beginning therapists to have a cotherapist when seeing families with children.

Self of the therapist. Several authors made recommendations about the attitude of the therapist and described a number of things therapists should be aware of regarding themselves, their family of origin, their attitudes toward children, and experiences they

have had with children (Combrinck-Graham, 1985; Moss-Kagel, et al., 1989; O'Brien & Loudon, 1985; Rober, 1998), because these attitudes influence what one does in therapy (O'Brien & Loudon). Other references urged that family therapists be able to play with families with young children (Kaslow, et al., 2000; J. S. Scharff, 1989; Zilbach, 1982, 1986). Several articles also described characteristics a therapist who wants to work with children should have including interest in children, warmth, willingness to be in the child's world, creativity, flexibility, playfulness, trust in self, tolerance, intimacy, nurturance, and responsiveness (Bloch, 1976; Combrinck-Graham, 1985; Cordell & Allen, 1997; Gordetsky & Zilbach, 1989; Harvey, 1994; Rober, 1998; Stith, et al., 1996).

Knowledge and skill. An abundance of articles in the literature described knowledge and skills family therapists should have to work with families with young children. These knowledge and skills were in the categories of child therapy, play therapy, child development, family development, child psychopathology, child assessment, and other techniques of including young children in family therapy such as art, fantasy, games, metaphor, and storytelling. Most references (a total of 38) recommended knowledge and skill in the areas of child development and play therapy.

Knowledge of child development helps one better understand families and children's play, know how to include children in therapy, and know how to communicate with the child and design and select tasks in therapy; assists one in educating parents on what to expect with their children and in normalizing their behavior; helps one adapt to the child's world; and informs the choice of appropriate play material (Anthony, 1973; Carr, 1994; Rober, 1998; Scott, 1999; Selekman, 1997; Zilbach, 1989). Training in play

therapy helps one facilitate, observe, and interpret children's play; better communicate with and understand children; and effect change in children and families (Ariel, 1996; Hardaway, 1990; McDermott & Char, 1974; Zilbach, et al., 1972).

Communication. Finally, many authors advocated family therapists knowing how to communicate with children through play and verbalization, how to use children's input in all phases of the therapeutic process, and how to teach adults how to respond to the ways children communicate (Combrinck-Graham, 1985; Cordell & Allen, 1997; Dare & Lindsey, 1979; Guttman, 1975; Levant & Haffey, 1981; Malone, 1979; Moss-Kagel, et al., 1989; O'Brien & Loudon, 1985; Taffel, 1991; Wolfe & Collins-Wolfe, 1983; Zilbach, 1982).

Expert Recommendations

Use of Play

In response to a question that asked what role young children should play in family counseling/therapy, many experts suggested that therapists should use play when including young children in family therapy. This finding is consistent with the research and clinical literature. One would infer that if therapists should use play, then they should have training in how to do so.

Beliefs About Curricula and Accreditation Standards

More experts agreed with a generalist approach than a specialization approach. This finding may reflect the experts' belief that all family therapists should know how to work with young children. A very high percentage of the experts agreed that accreditation

standards should be changed to include more core child-related courses. This result is consistent with their belief in the generalist approach.

Course Material

The following course material was recommended by more of the experts to be taken by all students: Lifespan Development, Family Development, Parent-Child Relationships, Child Abuse, Cultural Influences on Children, Parent Education, Family Play Therapy, Parent-Child Therapy, and Family Therapy with Children. Lifespan Development, Family Development, Parent-Child Relationships, and Family Therapy with Children were recommended by a high percentage of experts to be taken by all students. The following course material was recommended by more of the experts to be taken by students in a specialty: Child Psychopathology, Child Assessment, Special Populations, Child Psychotherapy, Play Therapy, Child Group Therapy, and School Therapy. All these recommendations seem consistent with those of the research and clinical literature except for play therapy and family development. A large portion of the references in the literature advised knowledge and skill in the area of play therapy, while more of the experts recommended it for students in a specialty. However, the experts did recommend family play therapy for all students. The opposite was true for family development. Few literature references proposed knowledge and skill in this area, but more of the experts recommended it for all students.

Experiential Activities

The majority of experts (over 50%) recommended all the activities of which they were asked. These results show the importance of experience in the training of family therapists and are consistent with the references from the research and clinical literature.

Other Comments

A few experts described the significance of supervision. This fits with their belief and that of the literature in the importance of experience in training family therapists to work with children. A few experts also mentioned that programs should help therapists with their comfort level in working with children. This finding is consistent with the literature's recommendations regarding the self of the therapist.

Overall, the references in the literature and the experts themselves saw young children as developmentally different from adults, especially because children mainly communicate through play. Therefore, family therapists need special knowledge and skill to work with them, otherwise therapists are in danger of excluding young children in therapy or not appropriately attending to their needs.

Comparison of Current Training with Literature and Expert Recommendations

Current training was the most similar to the literature and expert recommendations in three instances, all concerning course material. First, the highest percentage of programs had a required course in the areas of Lifespan Development and Other Development. Likewise, the accreditation standards of COAMFTE, CACREP, and CSWE Council on Accreditation all required coursework in human development. Lifespan Development was also recommended by a high percentage of experts for all students to take. In

addition, the related area of Child Development was the most recommended course in the literature. Second, about half of the CACREP programs offered an elective course in Child Psychotherapy, while about half the experts recommended this course to be taken by students in a specialty. Finally, few programs offered a required or elective course in the areas of Family Development, Child Psychopathology, and Child Assessment. Similarly, these courses were recommended by a small percentage of references in the literature. However, 87% of the experts recommended Family Development for all students, and 67% recommended that Child Psychopathology and Child Assessment to be taken by students in a specialty.

Current training was the most similar to the literature and expert recommendations regarding experiential activities in just one way. The only activity that was required by a high percentage of programs and recommended by a high percentage of experts was observation of family counseling/therapy with young children.

In contrast, current training was the most discrepant with the literature and expert recommendations in four ways concerning course material. First, the overall mean number of child-related courses per program was low when compared to the number of courses recommended by the literature and experts. Second, very few programs had courses in the following areas the experts recommended all students should take: Parent-Child Relationships, Child Abuse, Cultural Influences on Children, Parent Education, Family Play Therapy, Parent-Child Therapy, and Family Therapy with Children. Third, few programs had courses in the following areas the literature recommended: Child Psychotherapy, Play Therapy, Family Development, Child Psychopathology, and Child

Assessment. Fourth, Play Therapy was the second most recommended course area in the literature. Similarly, a moderate percentage of experts mentioned that therapists should utilize play when including young children in family counseling/therapy, and several references in the literature urged family therapists to know how to communicate with children through play. However, few programs required a course in this area.

Furthermore, current training was the most discrepant with the literature and expert recommendations in three ways concerning experiential activities. First, the percentages of programs that required various experiential activities were much lower than the percentages the experts recommended. Second, the amount of experiential activities that are currently required of students does not fit with the importance the literature put on the role of experience in training family therapists to work with young children. One expert seems to have summed up this difference well,

My strongest opinion is that academic programs don't do well when it comes to training therapists to work with children, because academic programs are inclined to emphasize theoretical learning over experience. Working with children and multigenerational families is a clinical (learn-by-doing) skill.

Finally, the program directors and experts disagreed on beliefs about curricula and accreditation standards. More experts than program directors agreed with a generalist approach, while more program directors agreed with a specialization approach. In addition, a much larger percentage of experts agreed that accreditation standards should be changed. These findings may reflect the greater importance the experts place on the need for more child-focused training in family counseling/therapy programs.

In summary, the words of one expert, “What MFT students should receive and actually receive is profoundly different.”

Limitations of Study

There are two main limitations to this study. First, a high rate of responses for the program director surveys and the expert interviews was not received. The particular group of program directors who responded to the survey may have been biased. It may be likely that these directors were those that are currently satisfied with how well their programs train their students. In addition, the experts who responded to the interview may have been biased. It is likely that the experts who responded were those who believe there should be more training in how to work with young children in family therapy.

Second, the percentage of syllabi received was very low. Therefore, it is difficult to make conclusions about the current content of child-related courses and generalize these inferences to all family counseling/therapy programs.

Recommendations for Training

In this section, recommendations are made concerning course material, experiential activities, and accreditation standards. Resources to support these recommendations are also described. The following recommendations are based on the recommendations of the experts from the expert interviews and of the research and clinical literature.

Course Material and Experiential Activities

All students should receive course material in lifespan development and parent-child relations and have knowledge and skill in doing family therapy with young children. In particular, students should know the developmental needs, issues, and norms of each

stage of the lifecycle and be able to apply these in practice. Knowledge and skill in family therapy with young children would include family play/activity therapy and possibly parent education and filial therapy. Other course material that can be dispersed throughout other courses includes child-related laws and ethics, child abuse, and cultural influences on children. Courses should also include a focus on the self of the therapist especially by helping students become more aware of themselves, their family of origin, their attitudes toward children, and experiences they have had with children and how these attitudes influence what they do with children in therapy. In addition, courses should assist students with their comfort level in working with children.

More electives should be available for students who are particularly interested in working with this population and want to specialize in this area. Course material would include child psychopathology, child assessment, special populations, child psychotherapy, child group therapy, and school therapy.

The experts and research and clinical literature disagree on whether all students should have knowledge and skill in play therapy and family development. All students can benefit from having course material in play therapy. In fact, play therapy is a logical prerequisite for course material in family play therapy. Family play therapy is a developmentally appropriate way of including children in family therapy and has been recommended by both the experts and the literature. In addition, play therapy is a prerequisite for filial therapy which was a course recommended by some of the experts. Material on family development can fit well with courses on lifespan development and parent-child relations that have already been recommended for all students. In this area,

students should know the norms and issues of the stages of the family lifecycle and should be able to translate them into practice.

These recommendations for course material that all students should take do not necessarily mean that several new courses should be added to current curricula. Instead, programs would be advised to revise current courses in lifespan development to also include parent-child relations and family development. Whenever possible, course material should be integrated to include a more developmental focus. However, many programs may need to add a course in family therapy with young children as just described. Finally, as one expert suggested, good textbooks that cover a lot of material can be used to integrate course material so that several new child-related courses required for all students are not needed.

Overall, the amount of experiential activities required of all students should be increased. These activities should include the opportunity to observe and watch videotapes of play therapy, family play therapy, and family therapy with young children, and have experience in doing each of these modalities. In addition, beginning therapists would be advised to use a cotherapist when doing conjoint family sessions with young children.

Accreditation Standards

Accreditations standards should be changed to require more core child-related course material and experiential training for all students in the areas listed above. This additional course material may result in a longer period of training for students, but the students would be more qualified to work with children and families with young children than

students who have not had this course material. The program directors' concern with the standards being too restrictive is well-noted. However, even with more requirements, programs can still be creative in how they teach this recommended course material.

Resources

Finally, for all these changes to occur, programs need the resources to support the changes. These resources include child-related facilities such as play therapy rooms, sandtray therapy rooms, and activity therapy rooms and instructors that have educational background and clinical and teaching experience in the area of working with young children in child therapy, in particular play therapy, and family therapy. These type of instructors would fulfill the requirement described in the accreditation standards of COAMFTE, CACREP, and CSWE Council on Accreditation.

A question arises then of who would be qualified to teach these proposed child-related courses. Programs may consider hiring child therapists who have experience in working with families and family therapists who are trained in play therapy or child therapy.

Recommendations for the Future

Further research should discover how satisfied graduates from accredited marriage and family counseling/therapy programs are with how well they have been trained to work with families with young children. They might also be asked what about their current training was most impactful to their practice and what changes they would recommend to programs. More in-depth study is needed of what content is currently being taught in the child-related courses of these programs. Also needed is more in-depth study of the instructors' clinical and teaching experience level and educational

background for these courses. Finally, a study should examine the therapeutic effectiveness of students from a pilot program that includes the recommendations made by this study.

In conclusion, readers who are interested in the topic of this study would be urged to impact change in programs and accreditation standards in several ways. For instance, more publications and presentations at professional conferences are needed in this area. Accreditation boards should also be made aware of the need for more effective training in family therapy with young children.

APPENDIX A

PROGRAM DIRECTOR PRETEST COVER LETTER

Jodi Crane
110A Quail Ridge
Glasgow KY 42141

Dr. Program Director
Department of
Name of University
City ST 12345

Dear Dr. Program Director:

As a director of an accredited marriage and family counseling or therapy program, you have been selected to participate in my dissertation research study through the University of North Texas in Denton, Texas. The purpose of this study is to examine how current family therapy programs train students to treat young children and to develop a model for educating family therapists to work with young children. Results from this study will benefit program directors like yourself, students in family therapy, and our future clients as we develop better ways to serve families with young children.

The enclosed survey is very brief and will require approximately ten minutes of your time. Your participation will contribute significantly to the compilation of accurate information.

The survey has been coded to permit follow-up on forms not returned. Your responses will remain completely confidential and the results will only be presented in a group format. You are encouraged to complete and return the last page of the survey if you are interested in receiving a summary of the results.

You have also been selected to pretest the survey. Please assess the survey for clarity, comprehensiveness, and acceptability. You may do this by editing the questions and answers or adding your comments throughout the survey. A revised survey will be sent to other experts based on your assessment.

Please return the survey in the self-addressed stamped envelope within the next four weeks. A package of gum is also included as a token of my deep appreciation for your cooperation in responding to the survey and its prompt return. If you have any questions, please do not hesitate to contact me by phone at (270) 678-5132 or by email at jcrane@glasgow-ky.com.

Sincerely,

Jodi Crane, M.A., LPC
Doctoral Candidate

APPENDIX B

PROGRAM DIRECTOR PRECONTACT LETTER

August 7, 2000

Jodi Crane
110A Quail Ridge
Glasgow KY 42141

«Title» «FirstName» «LastName»
«Address1»
«Address2»
«Address3»
«City», «State» «PostalCode»

Dear Dr. «LastName»:

I am a doctoral candidate in Counseling at the University of North Texas in Denton, Texas and also a faculty member in the Counseling program at Lindsey Wilson College in Columbia, Kentucky. In about a week you will be receiving a survey from me that is part of my dissertation research study. The purpose of this study is to examine how current family counseling/therapy programs train students to treat young children and to develop a model for educating family counselors and therapists to work with young children.

This letter is to request your cooperation with my study. Your participation is extremely appreciated and will contribute significantly to the compilation of accurate information about current family counseling/therapy programs.

If you have any questions when you receive the survey, please do not hesitate to contact me by phone at (270) 678-5132 or by email at jcrane@glasgow-ky.com or my faculty sponsor, Dr. Sue Bratton, at (940) 565-2066.

Sincerely,

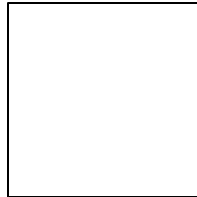
Jodi Crane, M.A., LPC
Doctoral Candidate

APPENDIX C
PROGRAM DIRECTOR SURVEY

*FAMILY COUNSELING/THERAPY WITH
YOUNG CHILDREN*

CONFIDENTIALITY GUIDELINES

1. Your participation is *voluntary*. You may withdraw from this study at anytime without penalty, prejudice, or loss of benefits.
2. Your participation is strictly *confidential*. Please do not put your name on this survey. The survey has been coded to permit follow-up on forms not returned. Your responses will only be seen by the primary investigator and her graduate faculty committee. Any reports on the research data will be based on group composites, not individual cases.
3. Your effort in answering all items is appreciated.
4. Please indicate that you have read and understood these guidelines by placing an "X" in the box below.



THANK YOU FOR YOUR PARTICIPATION!

This survey involves statements and questions regarding your master's program in marriage and family counseling/therapy. For the purposes of the survey, "young children" refers to children ages 2 to 10. "Family counseling/therapy" refers to a family with at least one young child and in addition, may have older children. If you wish to fill out the survey on-line, please send an email to jcrane@glasgowky.com.

The following is a list of child-related courses offered in your program or department. For each course, please mark how often the course is offered and estimate the percentage of master's students who take the course.

-----How often course is offered-----

Name of Course	Every semester/ quarter	Twice a year	Once a year	Every other year	As needed		% master's students

For all the instructors that currently teach the above child-related courses, please mark their years of clinical experience with an "X" and their years of teaching experience with a " ". (You do not need to list the instructors' names and there may not be as many instructors as there are courses. Instructor #1 does not necessarily correspond to Course #1 above.)

Instructor	0-5	6-10	11-15	16-20	21-25	26+
#1						
#2						
#3						
#4						

In the blank spaces, please answer the following questions regarding your program's practicum and internship sites.

Approximate number of sites that serve clients that are young children or families with young children _____

Total number of sites in the program _____

Please answer the following questions concerning your program's on-campus clinic.

1. In the space, estimate the percentage of clients that are young children or families with young children _____
2. Are there toys in the waiting room? (a) _____ yes
(b) _____ no
3. In the space, list the total number of counseling/therapy rooms in the clinic _____
- 4a. In the space, list the number of child-related counseling/therapy facilities in the clinic. (When a room has a multiple-use, count it in the category that it is used most frequently as.)
_____ play therapy rooms
_____ sandtray therapy rooms
_____ activity therapy rooms
- 4b. Are any of these facilities used to see young children individually? (a) _____ yes
(b) _____ no
- 4c. Are any of these facilities utilized for family counseling/therapy? (a) _____ yes
(b) _____ no

5. Check all the available child-related resources that students can bring into a counseling/therapy room for family counseling/therapy sessions.

- _____ toys
- _____ art supplies
- _____ bibliotherapy books

Please check all of the following experiential activities that are required of your students.

- _____ observation of “normal” children
- _____ observation of play therapy sessions
- _____ observation of family counseling/therapy sessions with young children
- _____ watch videotape of play therapy sessions
- _____ watch videotape of family play therapy sessions
- _____ do play therapy sessions with “normal” children
- _____ do play therapy sessions with client children
- _____ do family play therapy sessions with “normal” family
- _____ do family play therapy sessions with client family
- _____ other (Please specify: _____)
- _____ other (Please specify: _____)

Please rank how satisfied you are with how well your program prepares students to work with young children and families with young children.

Unsatisfied					Very satisfied
1	2	3	4	5	

Please check all of the following statements regarding students in marriage and family counseling/therapy programs with which you agree.

- _____ All students should be required to take the same core child-related courses (generalist approach).
- _____ Electives should be available for students who really want to focus on family counseling/therapy with young children (specialization approach).

Please check all of the following statements regarding accreditation in marriage and family counseling/therapy with which you agree.

- _____ Accreditation standards should be changed to require more core child-related courses.
- _____ Accreditation standards should be changed to include more electives for students who really want to focus on family counseling/therapy with young children.
- _____ Accreditation standards should remain the same.

Finally, please include a recent copy of the syllabi for the child-related courses listed on page 2 of this survey. These syllabi will remain confidential. They are included in this research study in order to determine what material is covered in these courses and what textbooks and articles are being used. The syllabi may be sent in the enclosed envelope (please add additional postage if necessary) or they may be sent under separate cover to the address below.

Jodi Crane
110A Quail Ridge
Glasgow KY 42141

Any comments about this survey

SUMMARY OF RESULTS

If you are interested in receiving a summary of the results of this research study, please complete the following information. To maintain your confidentiality, you may detach this page and mail it in a separate envelope to:

Jodi Crane
110A Quail Ridge
Glasgow KY 42141

Name: _____

Address: _____

THANK YOU AGAIN FOR YOUR PARTICIPATION!!

APPENDIX D
PROGRAM DIRECTOR SURVEY COVER LETTER

August 14, 2000

Jodi Crane
110A Quail Ridge
Glasgow KY 42141

«Title» «FirstName» «LastName»
«Address1»
«Address2»
«City», «State» «PostalCode»

Dear Dr. «LastName»:

As a director of an accredited marriage and family counseling/therapy program, you have been selected to participate in my dissertation research study through the University of North Texas in Denton, Texas. The purpose of this study is to examine how current family counseling/therapy programs train students to treat young children and to develop a model for educating family counselors and therapists to work with young children. Results from this study will benefit program directors like yourself, students in family counseling/therapy, and our future clients as we develop better ways to serve families with young children. There are no known risks to participating in this study.

The enclosed survey is very brief and will require approximately ten minutes of your time. Your participation will contribute significantly to the compilation of accurate information.

The survey has been coded to permit follow-up on forms not returned. Your responses will remain completely confidential and the results will only be presented in a group format. You are encouraged to complete and return the last page of the survey if you are interested in receiving a summary of the results.

Please return the survey in the self-addressed stamped envelope within the next four weeks. A package of gum is also included as a token of my deep appreciation for your cooperation in responding to the survey and its prompt return. If you have any questions, please do not hesitate to contact me by phone at (270) 678-5132 or by email at jcrane@glasgow-ky.com or my faculty sponsor, Dr. Sue Bratton, at (940) 565-2066. If you wish to fill out the survey on-line, please send me an email stating your desire.

Sincerely,

Jodi Crane, M.A., LPC
Doctoral Candidate
Graduate of a MFT program

You may wish keep this cover letter for your files.

APPENDIX E
FOLLOW-UP POSTCARD

Hi!

A few weeks ago you received a packet from me in the mail. This packet contains a survey called “Family Counseling/Therapy With Young Children” and is my dissertation. If you completed the packet, I THANK YOU. If you did not, I realize you are a very busy Person but please consider filling out the survey within the week so that I may graduate and get my life back. 😊
Thank you very much.

Jodi Crane

APPENDIX F

PROGRAM DIRECTOR FOLLOW-UP COVER LETTER

September 18, 2000

Jodi Crane
110A Quail Ridge
Glasgow KY 42141

«Title» «FirstName» «LastName»
«Address1»
«Address2»
«Address3»
«City», «State» «PostalCode»

Dear Dr. «LastName»:

About a month ago you received a survey entitled "Family Counseling/Therapy with Young Children." If you have recently returned this survey, I thank you for your prompt reply. If you have not yet had the opportunity to complete it or have misplaced the survey, enclosed is another copy for you.

I realize that you are a very busy person, but the enclosed survey is very brief and will require only about ten minutes of your time. Your participation will contribute significantly to the compilation of accurate information. Results from this study will benefit program directors like yourself, students in family counseling/therapy, and our future clients as we develop better ways to serve families with young children. There are no known risks to participating in this study.

The survey has been coded to permit follow-up on forms not returned. Your responses will remain completely confidential and the results will only be presented in a group format. You are encouraged to complete and return the last page of the survey if you are interested in receiving a summary of the results.

Please return the survey in the self-addressed stamped envelope within the week so that I may begin analyzing the data at the end of this month. If you have any questions, please do not hesitate to contact me by phone at (270) 678-5132 or by email at jcrane@glasgow-ky.com or my faculty sponsor, Dr. Sue Bratton, at (940) 565-2066. If you wish to fill out the survey on-line, please send me an email stating your desire.

Sincerely,

Jodi Crane, M.A., LPC
Doctoral Candidate
Graduate of a MFT program

APPENDIX G
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APPENDIX H
QUOTATIONS FROM THE RESEARCH
AND CLINICAL LITERATURE

017201 "It should be noted, however, that the correct interpretation of the child's use of play material for this purpose usually requires prior training in play therapy techniques." P. 396 (this purpose refers to play activities providing clues to the underlying issue at a particular point in therapy)

027301 "...family theorists have generally not received any intensive training in child development, while child psychiatrists and child psychologists are usually woefully untrained in transactional dynamics. The bringing together of the developmental and transactional within a single model should certainly provide a fuller understanding of family life." P. 7

047401 "Child psychiatry has painstakingly established the fact that the treatment of childhood disorders involves more than simply the education, counseling, or treatment of parents...Specialized attention and skill need to be paid to the disturbed child in order to understand and to treat him and his problems." P. 429

047402 "'Special techniques such as play therapy, storytelling, and ability to utilize fantasy can be profitably used in working with children by family therapists if they have the knowledge, skill, and interest to tap the rich psychic life of children. A few (Zilbach et al., 1972) family therapists are child-oriented enough to provide play materials other than to distract the child, to observe and interpret the play, and also allow the child to retreat into it if he is not ready to deal with particular issues." P. 433

047403 "For the research task which must provide techniques with which young children can be effectively involved in family therapy (for instance, how to understand, relate, and integrate the multiple levels of communication and interaction that occur so naturally in every family, into a therapeutic process) can be carried out only by genuine child and family experts. Better understanding of the unique and changing vulnerability of the child within the family, and how this factor influences the family system, must replace the simplistic notion that the child is only expressing the family or parental illness through his symptoms." P. 435

477401 "A therapist should know the developmental needs of children and be able to support the child's right to autonomy without minimizing the parents' rights." P. 59

057503 "...the therapist can play an educative role for adult family members by showing them how one may understand and respond to the child's communications as legitimate comments on his satisfactions or dissatisfactions with family functioning. In my opinion, this can be done by any therapist who has a conventional understanding of the possible symbolic significance of children's verbal and nonverbal activity. It does not require a great deal of equipment, and honors in the observance rather than in the breach of commitment to treating the family as a whole." P. 491

057504 “The understanding garnered from the insights of play therapy can thus be profitably combined with family therapy which is more verbally or insight-oriented.” P. 499

057505 “Since children communicate through play, movement, and seemingly irrelevant remarks, therapists must be taught to understand and use their contributions.” P. 499

067601 “...therapists should work with children who are amused and energized by them, whose sensibilities are enlarged by the young, and who are reasonably at peace with their special way of ordering and relating to things and people. It should be said that the therapist may be mistaken in his ideas about himself in this respect. If he has the notion that he cannot work with children, he ought to test this by exposing himself to the possible rewards of so doing.” P. 172

077901 “In this paper we have been principally stressing the ability of children to participate as full members of a family therapy group and our emphasis has been upon the understanding of the importance and meaning of the communications of children of all ages. Children can be offered interpretations and that putting such therapeutic communications in a form that is comprehensible by all the people of the family, whatever their ages, must be a skill available to family therapists. At the same time it is possible to involve the children in more active, i.e. less reflective, interpretative interventions, in, for example, drawing up a family tree or in the setting of family tasks to be carried out between sessions.” P. 268

087901 “Child psychiatrists doing family therapy have become aware that the knowledge base and clinical skills of child psychiatry play an important and, at times, critical role in their ability to carry out effective family therapy. They have learned that their emphasis on careful diagnosis, knowledge of child development, appreciation of the child’s contribution to his own and the family’s problems, and ability to utilize the fantasy, play, and verbalizations of children are all crucial to the conduct of family therapy.” P. 7

087902 “Child psychiatrists who are family therapists have long been aware of the many ways in which their child psychiatric knowledge base and clinical skills are crucial to the conduct of family therapy. At the most fundamental level this involves their ability to include children of all ages and to understand and utilize children’s play, fantasy, and verbalizations in family diagnostic and treatment process.” P. 12

547901 M.F.T. Core Curriculum includes two child-related courses: The Child as the Identified Patient a. Child Development in Family Context b. Child Psychopathology in a Family Context p. 18

557901 “Training in family therapy may be useful not only for its own self, but if used flexibly the trainee can achieve familiarity with a wide variety of treatment modalities.

The more experienced the clinician, the better able is he/she to adapt therapeutic goals, techniques, and the way he/she uses himself/herself to the needs and styles of different families. Thus, it is possible for someone trained in family therapy to have obtained familiarity and working proficiency not only in relating to the family as a system and in facilitating communication within that system, but also in diagnostic play interviewing and play therapy with children, group work with adolescents, marital therapy, and individual treatment.” P. 78

557902 “Ability to utilize behavioral contracting in order to help families negotiate specific issues, experience in interviewing adolescents, diagnostic play techniques with children, and couple therapy also are skills a family therapist needs in order to relate to families in a flexible, responsible way.” P. 80

108101 “Both play and family therapy are learned chiefly by experience. A structured and strategic method of working is useful early in the therapist’s learning as well as in treatment. But the therapist must outgrow a technical approach to his work. The theoretical structures act as platforms for expanding the experience component of therapy.” P. 245

118101 “The family therapist must have knowledge not only of the family system but of the particular stage of development of the individual family members, including the children. The family therapist also needs to understand the child’s nonverbal language and use of play to express fantasies, feelings, and conflicts, and be able to communicate with the child through the use of play.” P. 139

128201 “So the ‘real’ problem is the attitude of the therapist toward play—his or her knowledge of and experience with play. Most adults do not regard play as child’s work. And therapists who have been trained primarily to treat adult may easily recognize the theoretical importance of childhood but not when put into action, particularly by young children.” P. 65

128202 “Therapists need to recognize children’s play and drawings and include them in the therapeutic process in ways that will gradually become comfortable for the therapist and family members. It is not necessary to know all about the intricacies of the characteristics of the developmental level of children’s drawings. However, it is necessary to recognize that a child has drawn something and to make a very simple comment about it.” P. 66

288301 “Family play therapists should obviously have some training and experience in the therapeutic use of play, family systems, and psychodynamics. This person should feel secure in playing and possess a working knowledge of how to utilize the milieu as part of the treatment approach.” Pp. 69-70

298301 “However, to include all members of a family in therapy, it is helpful to be skilled in using verbal approaches as well as nonverbal ones in families with young children.” P. 87

148501 “There are specialized skills and information that must be acquired in order to work effectively with children. Family therapists need to learn about developmental norms for children of different ages.” P. 21

148502 “Therapists working with children in family therapy also need to know how to access communication through a variety of means including play, fantasy, drawing, music, rhythm, and movement. This requires a recognition that children experience the world differently than adults generally do.” P. 21

148503 “A third area of specialized information is an understanding of how children develop difficulties during the course of their growing up and how these difficulties are expressed. The child specialists call this information ‘psychopathology.’ However, family therapists who are child experts will understand these problems as related as much to the family context as to pathological processes within the child.” P. 21

148504 “A final point that I believe gets many family therapists into trouble when working with families of young children is an overemphasis on clear interpersonal boundaries and emotional differentiation. Therapists working with families in which troubled adolescents and young adults are the identified patients, must focus on issues of differentiation, but intimacy, nurturance, and responsiveness are far more salient than differentiation in families with young children. In fact, families with troubled pre-schoolers may actually suffer from being too differentiated.” P. 21

148505 “‘So how can family therapists who are uncomfortable with children learn to include them more effectively in family treatment? First, they can read the rather sparse literature on the subject. Second, they can recognize that the children are not the responsibility of the therapist in the session, but of their parents (thus supporting the function of the family system). Third, they can access all of the personal information they have about children in families, from their own childhoods, their own children, their friends’ children, and their experiences in novels, movies, and in public places where children are always to be seen—with and without their families. And fourth, they can consult with child specialists to learn more about what the child may be bringing to the family and to family therapy.’” P. 21

158501 “We feel it is particularly important for therapists to be aware of their own ambivalent attitudes toward children and in this respect we have found it helpful to examine the changing attitudes towards children in Britain in the last 500 years.” P. 82

158502 “We also believe that many therapists would do well to reflect on their own behavior towards children in therapy, particularly as any tendency to undervalue children

and give them an inferior status means that one is dismissing or ignoring an important part of the family system, and hence failing to adopt a truly systemic approach.” P. 84

158503 “Besides being aware of the history of childhood, it is useful for therapists to have an awareness of attitudes to children from a more philosophical point of view.” Pp. 84-85

158504 “We suggest that in order to serve children best, therapists need to be aware of their own attitudes to them and whether these lie within a liberal or restrictive philosophy. Unconsciously held attitudes are likely to influence therapy, so the more therapists understand their own reactions to children’s behaviour and the attitudes behind them, then the greater will be their understanding of children and the more effective their therapy. Also, in situations where the therapist espouses a liberal philosophy and the family a restrictive one, or *vice versa*, then therapy is likely to prove difficult until this difference has been acknowledged and clarified (e.g. in planning behavioural strategies therapists often suggest rewarding a child whom the parents think should only be punished).” P. 85

158505 “In addition, therapists need to be familiar with child development and be able to communicate with children at different stages of development in an appropriate manner.” P. 86

158506 “Therapists need to overcome their reluctance and difficulty in communicating with children and avoid too intellectual an approach to therapy.” P. 86

158507 “...we believe that for family therapy to be successful, it is vital that the therapist stays in charge. It is therefore crucial that therapists know how they are going to communicate with children and deal with the difficulties they may present so as to avoid being caught ‘on the hop,’ simply reacting to a child’s awkward behaviour and thereby becoming in danger of being ‘sucked in’ to the family system, hence losing therapeutic manoeuvrability. To remain in charge, it is helpful if therapists have a wide range of techniques at their disposal so they can then encounter and deal effectively with a wide range of situations from the attention-seeking disruptive four-year-old, to the silent, withdrawn adolescent.” P. 87

158508 “We, therefore, believe that live supervision teams are probably most effective not only when they contain people of different professional disciplines, and personality traits, but also when individuals characteristically use different ways of thinking. This diversity can then be fully exploited to give families the most effective therapy.” P. 97

168601 “It is helpful for the family therapist, especially the new family therapist, to have a cotherapist, when children are included in therapy sessions.” P. 8

178601 “In reviewing the practice of family therapy, it would seem that family therapists would profit from exposure to and direct training in innovative formats for working more creatively and effectively with children within a family systems framework. Typically, this kind of training should include experience in applying various forms of action therapy, including play therapy, with children and teenagers (Nickerson, 1980).” P. 67

178602 “Additionally, family therapists should be required to furnish evidence of such training in order to be licensed. A minimum of one such internship year should be requisite. Further, qualifying examinations should contain material from the field of child/adolescent assessment and therapy.” P. 67

308601 “Family play therapy is a valuable technique, however it is not for use by every therapist, nor should it be used indiscriminately in every case. One must already have a knowledge of the appropriateness of the various materials and methods of play therapy, as well as skill in working with family groups.” P. 250

468601 “An ability to participate in playful activities, combined with knowledge, facilitates a positive inclusion of young children in family therapy. However, gaining knowledge from lectures, articles, and even good books or plays, does not automatically overcome strongly developed adult attitudes and feelings.” P. 20

468602 “Reading about play may be of some assistance in overcoming reluctance to include children in family therapy.” P. 23

188701 “From child therapy, family therapists ought to learn how to communicate in the child’s language or take the further step of showing the parents how to do the same, so that they can respond helpfully to the child without needing the therapist to serve as an interpreter.” P. 610

198801 “Consequently some didactic and clinical experience would seem necessary to orient therapist trainees to the task of working therapeutically with children. The decision to include or exclude children in treatment does seem to depend upon therapists’ personal experience with children or their having personal experience via children of their own.” P.108

198802 “Clearly, there is a need to evaluate whether didactic coursework, or exposure, coursework, and supervised clinical experience with children in the context of the family.” P. 109

198803 “With regards to training, it is the author’s impression that training programs need to look more closely at the optimum balance of personal and professional supports to facilitate work with children.” Pp. 111-112

408901 “Advanced trainees wishing to treat children and their families need the following initial knowledge of both individual and family development and behavior prior to attempting an integration.

1. individual life cycle, particularly child development
2. the family life cycle
3. family systems
4. the relationship of individual symptoms to the family and vice versa
5. an understanding of one’s self and family of origin

With ninety years of writing about the nature of the psyche and thirty-five years of writing about the family from which to draw, the beginning therapist can feel overwhelmed about mastering this body of knowledge. We have no therapists if immediate mastery were a requirement. Becoming a therapist is a lifelong, dynamic process of development.” P. 124

408902 “Without going into full discussion of cognitive development, the exploration of how children communicate, particularly in play, is a specific knowledge that is basic to working with them.” P. 125

408903 “A knowledge of the family life cycle provides the beginning therapist a tool to assess the family and monitor its progress in treatment in the same way that knowing individual development serves for the individual. It provides a base line to determine the stage of the family and normative issues during that stage.” P. 127

418901 “Therapists need to be able to play with families with young children.” P. 159

418902 “The contextual holding capacity has to include comfort with play—and the accompanying noise, mess, and regression, all common features of ordinary family life.” Pp. 159-160

428901 “In order to understand children’s play, child training is useful as part of an introduction to the inclusion of children in family therapy, or, at least, to be grounded in child development.” P. 5

438901 “The family therapist learns a great deal by attending to play in family sessions—to its expression of themes which pertain to the individual child and to the family as a whole. It is not, however, necessary to be fully trained in play therapy technique to do so.” P. 76

448901 “The therapist’s ability to understand her countertransference reactions to children using such tools as associations, memories, self-knowledge, and supervision can increase her empathy and understanding of the whole family and their strengths.” P. 89

458901 “Our purpose is to demonstrate how young children and their play material contribute to a full understanding of the family and, secondly, show how knowledge of

child development and training in child and play therapy are essential to the therapist working with families.” P. 97

458902 “Seeing families with one or more young children raises the issues that effective teachers and group leaders must master; mainly, how to keep children under control. At the very least, the therapist must learn some of the techniques that are used by good teachers and good therapists:” p. 100

458903 “The necessity of recognizing and being tolerant of the ebb and flow of progression and regression as part of normal childhood development is crucial for both child and family work. We have also mentioned the need for therapists to learn ordinary limit-setting and other group therapy skills and interventions. The importance of being familiar with child and adolescent development and with developmentally appropriate avenues of expression and other child experiences is apparent.” P. 101

458904 “Child training teaches the therapist to tap the richness of the child’s contribution and to use it in the process of family treatment as well.” P. 102

209001 “Therapists should become as knowledgeable as possible about normal child development. Much of the behavior that parents find troublesome is transient. Children who are developing normally go through phases that are dominated by certain issues and behaviors.” P. 218

319001 “Family play therapy is commonly assumed to be just another form of either play therapy or family therapy. The skills required in individually oriented and developmentally appropriate play therapy are allied with those skills required in family-systems therapy.” P. 139

319002 “Thus, the therapist must not only be facile in family therapy and knowledgeable regarding family-systems issues, but he or she also must be competent and comfortable with developmental issues and individual play therapy techniques. The therapist must be able to facilitate appropriate play at the developmental level of the youngest individual, while understanding issues pertinent to other individuals and to the family system as a whole.” P. 141

569001 “They assert that only therapists trained specifically in work with young children can appreciate these developmental needs and respond to them effectively.” P. 275

219101 “Do we need special techniques to include children in family therapy? I think not, but we do need to use the approaches which are characteristic of family therapy, especially when children are present.” P. 374

229101 “Therapists who do not take into account these findings about children’s individual personalities and developmental stages risk a kind of therapeutic color blindness—they see the black and grey outlines of the pattern but miss the brilliant hues

that give it life. Without understanding individual temperament and family fit, for example, they can miss, or misinterpret, vital information about family functioning as a whole.” P. 22

229102 “Failing to communicate with a normal child can inhibit therapy, but failing to recognize inherent developmental delays in learning, language and motor skills in a child can do real harm.” P. 25

239101 “But to take advantage of this natural family resource, we need to learn how to harvest it. This requires knowing not only how to talk to children, but how to talk to children of different ages. If the first mistake we make is ignoring children altogether, the second is assuming that all children, whatever their ages, will respond to the same therapeutic approach. It is crucial to recognize that at each developmental stage, children have different styles of relating to others and different requirements of how others should relate to them.” P. 40 (It refers to children.)

369101 “In addition to techniques, family therapists need to understand the principles of working with children to facilitate the full participation of children in on-going family sessions. For comprehensive discussions on principles of working with children, the reader is referred to writings by child psychotherapists and family therapists who work with children (Ackerman, 1970; Aponte & Hoffman, 1973; Axline, 1969; Chasin, 1989; Combrinck-Graham, 1986, 1989; Keith & Whitaker, 1981; Moustakas, 1959; Satir, 1967; Scharff, 1989).” (techniques refer to rituals that empower objects with magical qualities, devising interventions with mystifying figures, using make-believe games in family enactments, family puppetry, kinetic family drawings, family art therapy, introduction of concrete objects, therapeutic metaphors, symptom prescription, and invariant prescription) p. 364

<”Briefly these writing emphasize several fundamental guidelines in conducting therapy with children. In working with children, the therapist attends to themes in the child’s play and interprets play as an expression of the child’s feelings and fantasies. The therapist aims to avoid excessive reliance on verbal interaction and instead uses simple words and short sentences. Questions about causes are phrased with “What” rather than “Why or How.” It is helpful for the therapist to move to the child’s level, to be actively involved with the child, and to follow the child’s exploration of themes and pace for disclosure. Limits may be set when necessary, but rules should be kept to a minimum.” P. 364>

369102 “Knowledge of principles of working with children may not necessarily lead to involving children in family sessions. In fact, knowledge of child therapy techniques may foster separate therapy sessions with the child and parents (e.g., Ornstein, 1985). Family therapists need techniques that specifically involve children in family sessions.” P. 364

249201 “Unless a training program explicitly seeks to be eclectic and maintain an eclectic stance, trainees are limited in their exposure to mentors and can become extremely narrow and overly specialized...To the extent that the graduate faculty in child clinical programs focuses primarily or exclusively on either child-focused or family-focused interventions, and ignores or derides the other, integration of these two approaches is impeded, and young clinicians will continue to describe themselves as either child therapists or family therapists.” Pp. 118-119

259301 “As a result of the field’s collaborative shift, family therapists can benefit by seeking the necessary training and expertise that will allow them to say, ‘Yes’ to ‘Do you do child therapy?’ This yes can then be followed by a sincere ‘And I’ll need you (the parent(s)) to help.’” P. 266

329301 “Expertise in play therapy and in working with family systems are the only prerequisites.” P. 289 (concerning family play therapy)

269401 “Third, at a theoretical level, methods of engaging children in therapy must be based on an integration of both the therapeutic literature and the child development literature.” Pp. 57-58.

269402 “This approach to including children in therapy can be adopted by therapists from any professional background that includes a grounding in the basic therapeutic skills needed to engage children in a helping relationship. The skills outlined here can be refined in brief intensive training workshops. Of course, being a parent helps too, but it’s not essential.” P. 58

339401 “Family play therapy is a complex process. The therapist must enter the therapy setting armed with a significant diversity of knowledge. This treatment modality requires an understanding of child development, family development, individual, family, and group process, as well as an ability to ‘be a healer [and]...transcend technique’ (Minuchin and Fishman, 1981, p. 1).” Pp. 15-16

539401 “Ideally, the Dynamic Play therapist should have educational background in family systems theory, in attachment, and in one of the major expressive arts therapies. Training in dance, drama, art, or play therapy usually prepares the clinician for the process aspects involved in using expressive activities. Central to the education of the creative/expressive arts therapist is the idea that psychological aspects of meaning are revealed in the process of expression used by clients. Training includes how to incorporate these process elements into the activity such that psychological meaning is made relevant and workable. While various theories may identify and organize these expressive elements in different ways, the focus on viewing the creative expressive processes as the primary therapeutic material is important. This training is essential in Dynamic Play Therapy.” Pp. 93-94

<"Dynamic Play Therapy is a style of family intervention that integrates movement, dramatic play, and video expression within therapy sessions. The goal of these activities is to help a family bring more creativity into their day-to-day interactions." P. 85>

539402 "As in many fields of family therapy, the more clinical experience the Dynamic Play therapist has in working with children and families the better. Perhaps the most helpful suggestion for a therapist who wishes to be a successful Dynamic Play therapist is to have experience watching normal, healthy families engage in expressive interactive experiences. While this can be done at almost any playground or park, it is important to also observe these family interactions in a playroom. These observations prove invaluable in grasping how the process of expressive improvisation at play comes naturally for healthy families." p. 94

539403 "Experience watching healthy families create expressive improvisations to solve problems is invaluable in recognizing how families with more difficult situations become stuck and trapped by their own expressive process. Families, for example, whose children have experienced sexual abuse, who have major attachment difficulties, or who are in developmental crisis can find even simple activities such as drawing together, playing tag, or storytelling truly painful and frustrating. Also, when a therapist can become familiar with what the normal play/expressive process looks and feels like, he or she knows what to encourage when families enter therapy who are stuck in conflict situations. Often, the most difficult thing is not only identifying how a problematic family reaches a conflict, but also generating enough motivation, playfulness, and imaginative ability to encourage personal creativity to meet such challenges. To do this, the therapist needs to have experience to encourage small, creative movements when they are seen." P. 94

539404 "Clearly, creativity is one of the strongest personal characteristics demanded of an effective Dynamic Play therapist. A Dynamic Play therapist should be able to tolerate the frustration of leaving some expression processes open from premature closure. Often, the Dynamic Play therapist is called on to model the expressive-creative process in difficult situations so as to set up and reframe problematic situations as more playful experiments in which the answer is not known or readily seen. In such situations, the therapist must guide the next creative solution. This demands that the therapist trust his or her own creative ability to see the problem and its solution as it is happening rather than expecting to see it before it happens." P. 94

539405 "Parallel to this personal creative ability is the therapist's ability to have security and trust in his or her own human and professional abilities to engage in interactions in which strong intimacy and affect are being expressed, negotiated, and defended against, even if only in a playful manner. Without such trust and security, the therapist may be tempted to stop, redirect, or offer boundaries that are so rigid that families are unable to truly explore creative options." P. 95

349601 “Fledgling therapists may find a co-therapist useful to help track the entire family.” P. 17 (concerning family play therapy)

359601 “The therapist uses play as a source of diagnostic information, as a medium of therapeutic communication, and as a precision instrument for effecting change. The latter application requires understanding of the therapeutic power of play. In the context of this method this concept refers to those properties of play which have the power to remove bugs. (Let us call them ‘bug-buster.’) The therapist must know these properties and be skilled in activating them effectively.” Pp. 6-7 (concerning strategic family play therapy)

389601 “In this vein, marriage and family therapy educators may want to consider requiring MFT students to have supervised individual play sessions with clinical and nonclinical children and/or explicit training in conjoint family pay therapy.” P. 84

389602 “Therapists who are interested in children, able to express warmth and connection to them, and willing to operate, at least in part, in the child’s world, will likely have more success involving children in therapy.” Pp. 84-85

389603 “If we intend to see family members together, we need to develop ways of doing so that make children’s full participation in the process possible.” P. 85

519601 “It is suggested that therapists working with children and families from a narrative framework can use their training in systemic or child psychotherapy approaches. For example, the hands-on experience with children in play therapy provides valuable skills in relating to young people in family therapy, as well as an increased awareness of relationship issues and therapeutic process.” P. 424

279701 “A flexible model of treatment necessitates a wide variety of therapeutic skills, including knowledge of both individual and family dynamics, flexibility and playfulness in relating to children, and the ability to communicate clearly with family members of all ages in negotiating and implementing the treatment plan.” P. 55

489701 “Having a good grasp of developmental theory can aid us in determining how best to communicate with the child and with designing and selecting therapeutic tasks that he or she is capable of understanding and performing.” P. 22

489702 “Therapists who treat children need to be knowledgeable about child development. By educating parents on what to expect developmentally with their children and helping them find the right ‘keys’ or course of action for supporting their children’s mastery of developmental tasks, we can have a much more meaningful impact on families.” P. 23

489703 “A good grasp of child development, particularly what a child is capable of cognitively understanding, feeling, and mastering behaviorally at any stage of development, can inform how we interview the child and what we choose to do with task

design and selection. By having this knowledge base, therapists can educate parents on what to expect at a given stage of development and normalize for parents child behaviors that typically occur at a particular age or in response to family life-cycle changes.” P. 211

529701 “One does not have to be an artist or be specially trained to use expressive arts in combination with narrative therapy. There are straightforward ways to broaden expression. For example, many children can be invited to show problem or counterproblem ideas in graphic form in a drawing or cartoon. It is not necessary to be an expert in expressive arts or play therapy, since the child is already an expert at play and, given a simple invitation, will go a long way; the adult merely has to be willing to tag along and take up the meanings that emerge.”

579801 “Undoubtedly, experiential training and supervision are essential for family therapists who want to include children in therapy. Thorough reflection on one’s own anxieties, hesitations, and vulnerability is of course important for all family therapists, but it is especially important for the therapist who doesn’t feel at ease in working with children in family therapy.” P. 202

579802 “Family therapists who want to work with children should prepare themselves for hard work. On the one hand, they must be able to tolerate uncertainty, chaos, and confusion. They must be aware that they won’t be able to control or understand everything in the session.” P. 206

579803 “The family therapist has to adapt to the world of the child. In the first place, this means to be aware of the child’s developmental stage.” P. 207

499901 “Family therapy training programs must provide trainees with at least one basic foundation course in child and family development which describes how these developmental issues translate into practice. In addition, trainees should be provided with a ‘hands-on’ skills class on techniques and methods for involving children in the family therapy process. It is imperative that family therapists enter the field equipped with the skills necessary to work with all of the members of a family system and to actively engage each member in a meaningful way.” P. 501

509901 “This entails: knowing what constitutes healthy child development; bringing children into therapy to learn more about who they really are; offering informed feedback and guidelines to parents; using our systems knowledge to help parents fit better with their children.” P. 32

589901 “Age-appropriate material should be available for small children in the therapy room. Good knowledge of child development will inform the choice of suitable age-appropriate play materials.” P. 90

599901 “Training needs to go beyond classroom instruction and role-plays, and instead involve direct interaction with mentally ill children and adolescents and their families, as well as provide the opportunity to observe professionals/supervisors working with this population.” P. 52

599902 “Practicum students who are selected to participate in a CAFSN group attend a one-day workshop on symptomatology and medications used with mentally ill children and adolescents.” P. 53

600001 “Family therapy with children requires that the therapist be knowledgeable about child and family development, developmental psychopathology, family systems theory, and techniques of culturally competent child and family assessment and intervention.” P. 189

600002 “Effective inclusion of young children in family therapy requires that the family therapist stay current on the changing demographics of children and families in our culture, be informed about the complexities of child development and family life cycle issues as related to families with young children, remain abreast of common child and family problems that often precipitate referrals for mental health services, and be familiar with the range of nonverbal and action-oriented techniques and psychoeducational approaches for working with families with young children.” P. 203

600003 “Perhaps most important, the therapist needs to be able to play with the child and the family and help the child and family play together.” P. 203

APPENDIX I
EXPERT PRETEST COVER LETTER

Jodi Crane
110A Quail Ridge
Glasgow KY 42141

Dr. Expert
Department of
Name of University
City ST 12345

Dear Dr. Expert:

As an expert in the field of child and family counseling and therapy, you have been selected to participate in my dissertation research study through the University of North Texas in Denton, Texas. The purpose of this study is to examine how current family counseling and therapy programs train students to treat young children and to develop a model for educating family therapists to work with young children. Results from this study will benefit family therapy educators and students in family therapy and our future clients as we develop better ways to serve families with young children.

The enclosed survey is very brief and will require approximately ten minutes of your time. Your participation will contribute significantly to the development of a model for educating family therapists.

The survey has been coded to permit follow-up on forms not returned. Your responses will remain completely confidential and the results will only be presented in a group format. You are encouraged to complete and return the last page of the survey if you are interested in receiving a summary of the results.

You have also been selected to pretest the survey. Please assess the survey for clarity, comprehensiveness, and acceptability. You may do this by editing the questions and answers or adding your comments throughout the survey. A revised survey will be sent to other experts based on your assessment.

Please return the survey in the self-addressed stamped envelope as soon as possible. A package of gum is also included as a token of my deep appreciation for your cooperation in responding to the survey and its prompt return. If you have any questions, please do not hesitate to contact me by phone at (270) 678-5132 or by email at jcrane@glasgow-ky.com

Sincerely,

Jodi Crane, M.A., LPC
Doctoral Candidate

APPENDIX J
EXPERT PRECONTACT LETTER

August 7, 2000

Jodi Crane
110A Quail Ridge
Glasgow KY 42141

«Title» «FirstName» «LastName»
«Address1»
«Address2»
«Address3»
«City», «State» «PostalCode»

Dear Dr. «LastName»:

I am a doctoral candidate in Counseling at the University of North Texas in Denton, Texas and also a faculty member in the Counseling program at Lindsey Wilson College in Columbia, Kentucky. In about a week you will be receiving a survey from me that is part of my dissertation research study. The purpose of this study is to examine how current family counseling/therapy programs train students to treat young children and to develop a model for educating family counselors and therapists to work with young children.

This letter is to request your cooperation with my study. Your participation is extremely appreciated and will contribute significantly to the development of a model for educating family counselors and therapists.

If you have any questions when you receive the survey, please do not hesitate to contact me by phone at (270) 678-5132 or by email at jcrane@glasgow-ky.com or my faculty sponsor, Dr. Sue Bratton, at (940) 565-2066.

Sincerely,

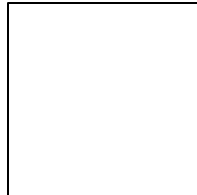
Jodi Crane, M.A., LPC
Doctoral Candidate

APPENDIX K
EXPERT INTERVIEW

*FAMILY COUNSELING/THERAPY WITH
YOUNG CHILDREN*

CONFIDENTIALITY GUIDELINES

1. Your participation is *voluntary*. You may withdraw from this study at anytime without penalty, prejudice, or loss of benefits.
2. Your participation is strictly *confidential*. Please do not put your name on this survey. The survey has been coded to permit follow-up on forms not returned. Your responses will only be seen by the primary investigator and her graduate faculty committee. Any reports on the research data will be based on group composites, not individual cases.
3. Your effort in answering all items is appreciated.
4. Please indicate that you have read and understood these guidelines by placing an “X” in the box below.

A large, empty square box with a thin black border, intended for the participant to place an 'X' in to indicate they have read and understood the guidelines.

THANK YOU FOR YOUR PARTICIPATION!

This survey involves statements and questions regarding master's level programs in marriage and family counseling/therapy. For the purposes of the survey, "young children" refers to children ages 2 to 10. "Family counseling/therapy" refers to a family with at least one young child and in addition, may have older children. If you wish to be interviewed instead of filling out the survey or wish to fill out the survey on-line, please contact the primary investigator via email at jcrane@glasgow-ky.com or by phone at (270) 678-5132.

In the space provided, please describe what role you believe young children should play in family counseling/therapy.

Please check all of the following statements regarding students in marriage and family counseling/therapy programs with which you agree.

- _____ All students should be required to take the same core child-related courses (generalist approach).
- _____ Electives should be available for students who really want to focus on family counseling/therapy with young children (specialization approach).

Please check all of the following statements regarding accreditation in marriage and family counseling/therapy with which you agree.

- _____ Accreditation standards should be changed to require more core child-related courses.
- _____ Accreditation standards should be changed to include more electives for students who really want to focus on family counseling/therapy with young children.
- _____ Accreditation standards should remain the same.

Please mark an “A” for all of the following child-related areas of training that you believe should be taken by *all* students in family counseling/therapy programs regardless of what accreditation standards currently say. Mark an “S” for all of the courses you believe should be included in a *specialty* within the program in working with families with young children. (Assuming you believe this.) You may also include other child-related material.

- _____ Lifespan Development (*covers conception through death*)
- _____ Family Development (*stages of the family lifecycle*)
- _____ Parent-Child Relationships (*AKA Parent-Child Interaction*)
- _____ Child Psychopathology
- _____ Child Assessment (*testing and appraisal*)
- _____ Child Abuse
- _____ Antisocial Behavior
- _____ Child-Related Laws
- _____ Cultural Influences on Children
- _____ Special Populations (*children with disabilities, mental retardation, etc.*)
- _____ Parent Education
- _____ Child Psychotherapy (*theory and methods of child intervention and may or may not include play therapy*)
- _____ Play Therapy
- _____ Family Play Therapy
- _____ Child Group Therapy
- _____ Parent-Child Therapy (*theory and methods of intervention with the identified child client and the parent(s)*)
- _____ Family Therapy with Children (*theory and methods of intervention with the whole family including siblings of the child client and may or may not include family play therapy*)
- _____ School Therapy
- _____ Other (Please specify: _____)
- _____ Other (Please specify: _____)
- _____ Other (Please specify: _____)

Go on to pg. 4.

Please check all of the following experiential activities that you believe students should have.

- ☐ observation of “normal” children
- ☐ observation of play therapy sessions
- ☐ observation of family counseling/therapy sessions with young children
- ☐ watch videotape of play therapy sessions
- ☐ watch videotape of family play therapy sessions
- ☐ do play therapy sessions with “normal” children
- ☐ do play therapy sessions with client children
- ☐ do family play therapy sessions with “normal” family
- ☐ do family play therapy sessions with client family
- ☐ other (Please specify: _____)
- ☐ other (Please specify: _____)

Please list any other comments you have about what you believe master’s level marriage and family counseling/therapy programs *should* be doing to educate their students to work with families with young children.

Go on to pg. 5.

Please answer the following questions about yourself.

Years of clinical experience _____

Years of teaching experience _____

Theoretical orientation _____

How do you view yourself? (Mark all that apply.)

- (a) _____ Child therapist
- (b) _____ Play therapist
- (c) _____ Family therapist
- (d) _____ Counselor educator
- (e) _____ Other (Please specify: _____)

Finally, please list the names of other experts you believe the primary investigator should interview about this topic and ways they can be contacted (address, email address, phone number).

SUMMARY OF RESULTS

If you are interested in receiving a summary of the results of this research study, please complete the following information. To maintain your confidentiality, you may detach this page and mail it in a separate envelope to:

Jodi Crane
110A Quail Ridge
Glasgow KY 42141

Name: _____

Address: _____

THANK YOU AGAIN FOR YOUR PARTICIPATION!!

APPENDIX L
EXPERT COVER LETTER

August 14, 2000

Jodi Crane
110A Quail Ridge
Glasgow KY 42141

«Title» «FirstName» «LastName»
«Address1»
«Address2»
«Address3»
«City», «State» «PostalCode»

Dear Dr. «LastName»:

As an expert in the field of child and family counseling/therapy, you have been selected to participate in my dissertation research study through the University of North Texas in Denton, Texas. The purpose of this study is to examine how current family counseling/therapy programs train students to treat young children and to develop a model for educating family counselors and therapists to work with young children. Results from this study will benefit family counseling/therapy educators, students in family counseling/therapy, and our future clients as we develop better ways to serve families with young children. There are no known risks to participating in this study.

The enclosed survey is very brief and will require approximately ten minutes of your time. Your participation will contribute significantly to the development of a model for educating family counselors and therapists.

The survey has been coded to permit follow-up on forms not returned. Your responses will remain completely confidential and the results will only be presented in a group format. You are encouraged to complete and return the last page of the survey if you are interested in receiving a summary of the results.

Please return the survey in the self-addressed stamped envelope within the next four weeks. A package of gum is also included as a token of my deep appreciation for your cooperation in responding to the survey and its prompt return. If you have any questions, please do not hesitate to contact me by phone at (270) 678-5132 or by email at jcrane@glasgow-ky.com or my faculty sponsor, Dr. Sue Bratton, at (940) 565-2066. If you wish to fill out the survey on-line, please send me an email stating your desire.

Sincerely,

Jodi Crane, M.A., LPC
Doctoral Candidate
Graduate of a MFT program

You may wish to keep this cover letter for your files.

APPENDIX M

EXPERT FOLLOW-UP COVER LETTER

September 18, 2000

Jodi Crane
110A Quail Ridge
Glasgow KY 42141

«Title» «FirstName» «LastName»
«Address1»
«Address2»
«Address3»
«City», «State» «PostalCode»

Dear Dr. «LastName»:

About a month ago you received a survey entitled "Family Counseling/Therapy with Young Children." If you have recently returned this survey, I thank you for your prompt reply. If you have not yet had the opportunity to complete it or have misplaced the survey, enclosed is another copy for you.

I realize that you are a busy person, but the enclosed survey is very brief and will require only about ten minutes of your time. Your participation will contribute significantly to the development of a model for educating family counselors and therapists. Results from this study will benefit family counseling/therapy educators, students in family counseling/therapy, and our future clients as we develop better ways to serve families with young children. There are no known risks to participating in this study.

The survey has been coded to permit follow-up on forms not returned. Your responses will remain completely confidential and the results will only be presented in a group format. You are encouraged to complete and return the last page of the survey if you are interested in receiving a summary of the results.

Please return the survey in the self-addressed stamped envelope within the week so that I may begin analyzing the data at the end of the month. If you have any questions, please do not hesitate to contact me by phone at (270) 678-5132 or by email at jcrane@glasgow-ky.com or my faculty sponsor, Dr. Sue Bratton, at (940) 565-2066. If you wish to fill out the survey on-line, please send me an email stating your desire.

Sincerely,

Jodi Crane, M.A., LPC
Doctoral Candidate
Graduate of a MFT program

APPENDIX N

REQUIRED TEXTBOOKS USED BY TWO COURSES

Lifespan Development

Carter, B., & McGoldrick, M. (Eds.) (1999). The expanded family life cycle (3rd ed.). Boston: Allyn & Bacon.

McGoldrick, M., Pearce, J. K., Giordano, J. (Eds.). (1996). Ethnicity in family therapy (2nd ed.). New York: Guilford.

Sigelman, C. K. (1999). Life-span human development (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Family Development

Carter, B., & McGoldrick, M. (Eds.) (1999). The expanded family life cycle (3rd ed.). Boston: Allyn & Bacon.

Other Development

Crain, W. (2000). Theories of development: Concepts and applications (4th ed.). Upper Saddle River, NJ: Prentice Hall.

Child Psychotherapy

Brems, C. (1993). A comprehensive guide to child psychotherapy. Boston: Allyn & Bacon.

Combrinck-Graham, L. (1989). Children in family contexts: Perspectives on treatment. New York: Guilford.

Vernon, A. (1999). Counseling children and adolescents (2nd ed.). Denver: Love.

Parent-Child Therapy

Wachtel, E. F. (1994). Treating troubled children and their families. New York: Guilford.

APPENDIX O

REQUIRED TEXTBOOKS USED BY ONE COURSE

Lifespan Development

- Angelou, M. (1970/1993). I know why they caged bird sings.
- Balswick, J., & Balswick, J. (1999). The family: A Christian perspective on the home (2nd ed.). Grand Rapids: Baker Books.
- Berger, K. S. (1998). Human development: The developing person through the life span (4th ed.). New York: Worth.
- Colarusso, C. (1992). Child and adult development.
- Combrinck-Graham, L. (Ed.). (1998). Children in family contexts: Perspectives on treatment. New York: Guilford.
- Falicov, C. (1991). Family transitions: Continuity and change over the life cycle. New York: Guilford.
- Fowler, J. (1981/1995). Stages of faith.
- Gottfried, A. E., & Gottfried, A. W. (1994). Redefining families: Implications for children's development. Plenum.
- Harris, J. R. (1999). Nurture assumption: Why children turn out the way they do. Touchston.
- Jolley, J. M., & Mitchell, M. L. (1996). Lifespan development: A topical approach. Madison, WI: Brown & Benchmark.
- Kubler-Ross, E. (1969). On death and dying.
- Loder, J. (1998). The logic of the spirit.
- Miller, P. (1993). Theories of developmental psychology. New York: W. H. Freeman.
- Newman & Newman (1999). Development through life: A psychosocial approach (7th ed.).
- Santrock, J. (1995). Life-span development (5th ed.). Madison, WI: Brown & Benchmark.
- Stevenson-Moessner, J. (Ed.). (2000). In her own time.
- Wainrib, B. (Ed.). (1992). Gender issues across the life cycle. New York: Springer.

Family Development

- Balswick, J., & Balswick, J. (1999). The family: A Christian perspective on the home (2nd ed.). Grand Rapids: Baker Books.
- Brod, H. (1994). Theorizing masculinities: Research on men and masculinities. London: Sage.
- Diessner, R. (Ed.). (1997). Sources: Notable selections in human development. Guilford, CT: Dushkin/McGraw Hill.
- Elium, D., & Elium, J. (1994). Raising a daughter. Berkely, CA: Celestial Arts.
- Falicov, C. (1991). Family transitions: Continuity and change over the life cycle. New York: Guilford.
- Haley, J. (1986). Uncommon therapy. NY: Norton.
- Harris, J. R. (1999). Nurture assumption: Why children turn out the way they do. Touchston.
- McGoldrick, M., Pearce, J. K., Giordano, J. (Eds.). (1996). Ethnicity in family therapy (2nd ed.). New York: Guilford.

- Pollack, W. (1998). Real boys: Rescuing our sons from the myths of boyhood. New York: Henry Holt.
- Smith, G. (1995). Strengthening aging families: Diversity in practice and policy. London: Sage.
- Walsh, F. (1993). Normal family processes. New York: Guilford.

Other Development

- Bee, H. (1997). The developing child (8th ed.). New York: Addison-Wesley Longman.
- Bjorklund, D. F. Children's thinking: Developmental functions and individual differences (3rd ed.). Belmont, CA:
- Campbell, J. (1976). The portable Jung. New York: Penguin.
- Cote, J. E., & Allahar, A. L. (1996). Generation on hold: Coming of age in the late twentieth century. New York: New York University.
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- Fisher, C. B., & Lerner, R. M. (1994). Applied developmental psychology. New York: McGraw-Hill.
- Goldhaber, D. E. (2000). Theories of human development: Integrative perspectives. Mountain View, CA: Mayfield.
- Green, M. (1989). Theories of human development: comparative approach. Englewood Cliffs, NJ: Prentice-Hall.
- Hart, C. H. (1993). Children on playgrounds: Research perspectives and applications. Albany: State University of New York.
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- Kagitcibasi, C. (1996). Family and human development across cultures. Mahwah, NJ: Erlbaum.
- LeFrancois, G. R. (1999). The lifespan (6th ed.). Belmont, CA: Wadsworth.
- Marion, M. (1998). Guidance of children (5th ed.). Columbus: Merrill/Prentice Hall.
- Maslow, A. H. (1998). Toward a psychology of being (3rd ed.). New York: John Wiley & Sons.
- Merrell, K. W., & Gimpel, G. A. (1998). Social skills of children and adolescents: Conceptualization, assessment, and treatment. Mahwah, NJ: Erlbaum.
- Miller, P. H. (1996). Theories of developmental psychology (3rd ed.). New York: Freeman.
- Moen, P., Elder, G. H., Jr., & Luscher, K. (1995). Examining lives in context: Perspectives on the ecology of human development. Washington, DC: American Psychological Association.
- Park, R. D., Ornstein, P. A., Rieser, J. J., & Zahn-Waxler, C. (Eds.). (1994). A century of developmental psychology. Washington, DC: American Psychological Association.
- Plomin, R., & McClearn, G. E. (1993). Nature, nurture, and psychology. Washington, DC: American Psychological Association.

Rebok, G. W. (1987). Life-span cognitive development. New York: Holt, Rinehardt, & Winston.

Wadsworth, B. J. (1996). Piaget's theory of cognitive and affective development (4th ed.). White Plains, NY: Longman.

Werner, E. E., & Smith, R. S. (1992). Overcoming the odds: High risk children from birth to adulthood. Ithaca, NY: Cornell University.

Youniss, J., & Yates, M. (1997). Community service and social responsibility. Chicago: University of Chicago.

Parent-Child Relationships

Harwood, R. L., Miller, J. G., & Irizarry, N. L. (1995). Culture and attachment: Perceptions of child in context. New York: Guilford.

Myrick, R. Developmental guidance and counseling.

Orton, G. L. (1996). Strategies for counseling with children and their parents. New York: Brooks/Cole.

Parsons, H. (1997). Aggression in our children: Coping with it constructively. Northvale, NJ: Jason Aronson.

Robin, A., & Foster, S. (1989). Negotiating parent adolescent conflict: A behavioral family systems approach. New York: Guilford.

Taylor, J. F. (1997). Helping your hyperactive/ADD child. Rocklin, CA: Prima.

Teyber, E. (1992). Helping children cope with divorce. San Francisco: Jossey-Bass.

Wachtel, E. F. (1994). Treating troubled children and their families. New York: Guilford.

Wittmer, J. Managing your school counseling program.

Youngs, B. B. (1995). Stress and your child. New York: Ballantine.

Child Assessment

American Psychiatric Association. (1994). Diagnostic criteria from DSM-IV. Washington, DC: Author.

Morrison, J. (1995). DSM-IV made easy: The clinician's guide to diagnosis. New York: Guilford.

Child Abuse

Briere, J., Berliner, L., Bulkey, J. A., Jenny, C., & Reid, T. (1996). The APSAC Handbook on child maltreatment. Thousand Oaks, CA: Sage.

Hermann, J. (1992). Trauma and recovery. Basic Books.

Parent Education

Dreikurs, R. Children: The challenge.

Gordon, T. Teaching children self-discipline. Solana Beach, CA: Effectiveness Teaching Press.

Grunwald, R. Guiding the family.

Hamner, T. J., & Turner, P. H. (1990). Parenting in contemporary society (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall.

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Soltz, R. Study Group Leader's Manual.

Child Psychotherapy

- Ammerman, R. T., & Hersen, M. (1997). Handbook of prevention and treatment with children and adolescents. New York: John Wiley & Sons.
- Bodiford-McNeil, C., Hembree-Kigin, T. L., & Eyberg, S. M. (1996). Short-term play therapy for disruptive children. King of Prussia, PA: The Center for Applied Psychology.
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- Vernon, A. (1996). Developmental assessment and intervention with children and adolescents. American Counseling Association.
- Weaver, A. J., Preston, J. D., & Jerome, L. W. (1999). Counseling troubled teens and their families: A handbook for pastors and youth workers. Nashville: Abingdon.
- Webb, N. B. (Ed.). (1991). Play therapy with children in crisis: A casebook for practitioners. New York: Guilford.

Play Therapy

- Hembree-Kigin, T. L., & McNeil, C. B. (1995). Parent-child interaction therapy. New York: Plenum.
- O' Connor, K. J. (2000). The play therapy primer (2nd ed.). New York: Wiley & Sons.
- Family Play Therapy
- Gil, E. (1995). Play in family therapy. NY: Guilford.
- Schaefer, C., & Carey, L. (1994). Family play therapy. NY: Aronson.
- Parent-Child Therapy
- Hay, G. N. Parenting that enhances life.
- Metcalfe, L. (1997). Parenting toward solutions. Paramus, NJ: Prentice Hall.

Orton, G. L. (1996). Strategies for counseling with children and their parents. New York: Brooks/Cole.

Robin, A., & Foster, S. (1989). Negotiating parent adolescent conflict: A behavioral family systems approach. New York: Guilford.

Schaefer, Briesmeister, & Fitton. (1984). Family therapy techniques for problem behaviors of children and teenagers. San Francisco: Jossey-Bass.

Taylor, R. Minority families in the United States. Paramus, NJ: Prentice Hall.

School Therapy

Baker, Stanley, B. (1996). School counseling for the twenty-first century (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Jones, S. (1992). Guidance in Montana: Guidelines for program development K-12. Helena, MT: Office of Public Instruction.

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analysis of quotations from the literature concerning training and through interviews of child and family therapy experts (65% response rate).

The results revealed the number of courses recommended by the literature and experts was much greater than the number of child-related courses per program and a great variety of textbooks were used. Accreditation standards also required little child-related course material. The on-campus clinics had low percentages of child-related facilities but high percentages of child-related resources. The results also showed the experts recommended much greater percentages of experiential activities than were required by the programs. Finally, a much larger percentage of experts than program directors agreed that accreditation standards should be changed to include more child-related courses.